University of Suffolk

MAPPING SEXUAL VIOLENCE SERVICE PROVISION IN SUFFOLK

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Abbreviations

IHWB	Institute for Health and Wellbeing, University of Suffolk
ISJC	Institute for Social Justice and Crime, University of Suffolk
ISVA	Independent Sexual Violence Advisor
MASH	Multi Agency Safeguarding Hub
NHS	National Health Service
PCC	Police and Crime Commissioner
SARC	Sexual Assault Referral Centre
SiT	Survivors in Transition
SNEE ICB	Suffolk and North East Essex Integrated Care Board
SSP	Suffolk Safeguarding Partnership
TiP	Trauma Informed Practice

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Executive Summary

The Institute for Social Justice and Crime (ISJC) and the Institute of Health and Wellbeing (IHWB) at the University of Suffolk (UoS) were commissioned on 2 December 2024 to map the current provision and commissioning of sexual violence services in Suffolk.

Three research methods were used: (1) a rapid evidence assessment, to create both a scoping review of existing academic literature and an understanding of the definitions of terminology, and the language used to describe sexual violence; (2) a review of aggregated or publicly available data provided by practitioners, to gain a wider picture of the landscape of sexual violence services; and (3) a public call for evidence via a survey and interviews, to hear the lived experiences of victim-survivors, support providers, and commissioners who fund sexual violence provision. This report covers sexual violence service provision in Suffolk which commonly support or refer on victim-survivors and third-party victims.

Our findings suggest the strengths which are most valued in Suffolk are:

1. Specialist support in the voluntary sector (when available).
2. The variety and quality of services available.
3. Good relationships between funders and providers.
4. The importance of victim-survivors being believed and being able to share their lived experiences with specialist service providers.
5. The involvement of Independent Sexual Violence Advisors (ISVAs) (where appropriate). ISVAs were singled out by many victim-survivors as an important provision.

Key issues and gaps in provision identified based on findings from the public call for evidence and the wider (national) literature were:

1. The signposting to support is often unclear and deters victim-survivors seeking help.
2. A lack of signposting and awareness of support available for third party victim-survivors (those affected but not directly targeted as a victim).
3. Delays in referrals and victim-survivors gaining access to support.
4. Difficulty for victim-survivors who live in rural areas gaining support due to the urban locale of services.
5. Specialist, therapeutic support is valued, but not always available.
6. Delays in the criminal justice process, linked back to loss of victim-survivor confidence, affecting attrition and subsequent conviction rates.
7. The lack of regular, guaranteed funding, so support services are not able to meet demand or extend support to existing victim-survivors.
8. The closure of support services, such as Suffolk Rape Crisis, putting further demand on existing services.

The recommendations and issues provided here are evidenced in our surveys, interviews and broader literature search. Our findings outline the local level of sexual violence support available in the Suffolk area, which reflect the national picture of need and provision and are in line with findings from other Suffolk-based research (Hermolle, 2023). As the Sexual Violence landscape is a complex system, the national picture often affects the local picture — i.e. national funders affect local funders and commissioners, which impact on the local provision, both specialist and general, and those satellite services such as health and education that could become tangentially connected. Thus, the system needs to be considered as a whole, and a collaborative and joined-up systems thinking approach would be of benefit to both victim-survivors and providers.

Recommendations

Based on the findings from our investigations, our recommendations have been co-produced by the commissioners of this report and the research team. We have proposed a definition of sexual violence for immediate use:

> *Sexual violence means unwanted sexual behaviour that happens against a person's will. It may involve physical force or violence or, more commonly, other forms of coercion (pressure), including threats, manipulation or power over the affected person.*

Additional consultation with victim-survivors and professionals could support the accessibility and acceptability of the proposed definition and inform the development of an easy read definition to promote wider accessibility for children and young people, people with learning difficulties and people with learning disabilities. Victim voice and understanding the lived experience of victim-survivors is fundamental to all outcomes and must be central to all recommendations. The recommendations are as follows and are linked throughout the report.

Please see Page 7 for the summary of recommendations.

Figure 1: Summary of Recommendations

Introduction

Background

In the UK, sexual violence services are commissioned primarily by local authorities, Police and Crime Commissioners (PCCs) and the National Health Service (NHS). The PCCs and NHS Integrated Care Boards (ICB) are responsible for commissioning sexual violence services in their respective areas, assessing the needs of their local population and determining the types of services required, such as Sexual Assault Referral Centres (SARCs) and counselling services. Between 2022–2025, £147million was allocated by the government for core victim support services (Gov.UK, 2022). As the lead commissioner for SARCs, NHS England has developed strategic partnerships with the Home Office, PCCs and the Ministry of Justice (MoJ) to help address these issues and improve services for the victims and survivors of sexual assault and abuse. The SARC for Suffolk is The Ferns which can be accessed independently or via the police (Suffolk Police, 2025).

Despite progress through legislation, awareness campaigns and services, sexual violence remains rooted in harmful societal attitudes and behaviours. Continued efforts are needed to promote prevention, support survivors and foster a culture of consent and respect. Addressing these issues requires policymakers, service providers and stakeholders to allocate resources, ensure consistent service standards and improve coordination to provide timely, trauma-informed, survivor-centred care.

Local accountability and statutory providers include the Suffolk PCC Accountability and Performance Panel; the Supporting Victims Sub-Group, made up of representatives from various departments and includes colleagues from the PCC for Suffolk, and the Rape and Serious Sexual Offences (RASSO) Joint Operational Improvement Meeting (JOIM). Through the Local Criminal Justice Board, Suffolk Constabulary works closely with its criminal justice partners to provide effective services to victims. Court backlogs are not being reduced, and delays are now emerging in the magistrates courts as well as the crown courts. This issue continues to be actively monitored through the Local Criminal Justice Board and through representation by the National Police Chief Council Criminal Justice Leads and Suffolk Constabulary's Victim and Witness Care Unit.

Working together with partner agencies through the Safer Stronger Communities Board (SSCB) is considered vital to the local response and together they have developed a strategy to help reduce and prevent violence against women and girls (VAWG). Additional partnership working includes the Suffolk Constabulary Rape Scrutiny Panel, Sexual Violence and Abuse Partnership (SVAP, run by Suffolk County Council [SCC]); Health and Wellbeing Board; Community Safety Partnership; Safer Stronger Communities Board; VAWG Steering Group; Suffolk and North East Essex (SNEE) Safeguarding; Police Rape Scrutiny Panel; Safeguarding Partnership; VAWG Steering Group (run by SCC); Crown Prosecution Service (CPS) RASSO regional scrutiny panel; Criminal Exploitation Hubs/Multi-Agency Criminal Exploitation Panels (MACE) and Make a Change Team.

According to a recent national evaluation, obtaining funding for voluntary service suppliers is chaotic: most commonly from charitable trusts and fundraising (~83%), ~78% of providers are funded by the Rape and Sexual Abuse Support Fund, and ~33% receive grant funding from local authorities i.e., NHS, ICB. Service competition for inconsistent and transient funding was highlighted as a barrier to service delivery (Damery et al, 2024). The Ministry of Justice, Home Office and Department of Health and

Social Care provide national guidance and standards for commissioning sexual violence services. This includes guidance on best practices, service delivery models and quality standard provision across the country. The scoping review for Suffolk suggests that guidance and best practice exists but is limited in availability. As an example, some interviewees argued that Suffolk should further align aspects of its commissioning with national norms and standards, promoting the accessibility of the ISVA service by maintaining a clearer boundary from police.

Local authorities and ICBs often collaborate with police forces, the CPS and specialist Voluntary, Community and Social Enterprise (VCSE) organisations to commission integrated services. VCSE services are shown to provide vital advocacy for victim-survivors and timely support may reduce the costs to the NHS, particularly in child sexual abuse cases (Adisa, Hermolle and Ellis, 2022). This ensures a coordinated response and support for victims of sexual violence across different agencies and sectors. Before commissioning services, local authorities and ICBs typically conduct needs assessments to understand the local demand for sexual violence services, they may also consult with existing service providers, victim support groups and other stakeholders to inform the commissioning process. Once the service requirements are defined, local authorities and ICBs go through a procurement process to select suitable service providers. This often involves a competitive tendering process, where interested organisations submit proposals and bids. Successful organisations are awarded contracts to deliver the commissioned services for a specific duration, typically ranging from three to five years.

Reports of rape, domestic abuse and sexual violence are increasing, yet under-reporting remains a challenge (ONS, 2022). Concerns about precarious funding and wide variations in access to support nationally and locally are highlighted by the closure of Suffolk Rape Crisis in 2024, which was widely attributed to the precarious funding climate for sexual violence service providers. However, interview data points to other factors underlying the reasons for closure; namely, internal staffing issues and a hesitancy about collaboration with other services due to competitive funding. A mapping exercise is timely, as Suffolk County Council's (SCC) Violence Against Women and Girls (VAWG) strategy is under review for renewal (Safer Stronger Communities Board, 2022).

The Suffolk Serious Violence Duty Partnership (SCC, 2025) is now underway and implementation of the Duty to Collaborate under the Victim and Prisoners Act (Legislation.Gov.UK, 2024) is likely to go live in 2026, addressing inefficiencies in the way victim support services are commissioned. The Suffolk Serious Violence Strategy (SCC, 2025) recognises the local prevalence of sexual violence: One in 10 of all serious violence offences in Suffolk are related to sexual violence. Recorded sexual offences in Suffolk were slightly above the national and regional average in 2021–2022 (2,716 incidents) and 2022–2023 (2,717 incidents). In 63% of sexual offences the perpetrator is known to the victim and 42% of physical abuse, 63% of psychological abuse cases and 25% of sexual abuse cases are not linked to the victim's home. A total of 2,143 rape and serious sexual assaults and 1,294 child sexual abuse (CSA) crimes were reported to Suffolk Constabulary in 2022–2023. 30% of CSA cases were classified as non-recent (SCC, 2025).

Recent research by the Institute for Social Justice and Crime (ISJC; Hermolle, 2023) identified systemic issues affecting sexual violence services in Suffolk, including capacity limits and budgetary constraints. The closure of services places a significant burden on the remaining providers and reduces available support for victim-survivors, who can be seen in the referrals data gathered from providers: for example, Survivors in Transition (SiT) saw a large jump in referrals from Norfolk and Suffolk NHS Foundation Trust (NSFT) sources (i.e. mental health, 111 calls etc) from 410 in 2023 to 489 in 2024. SARCs also saw a notable increase in self-referrals from 90 and 95 in 2022–2023 to 142 in 2024 (see figures in Referrals and Reporting Data section). It is difficult to directly attribute this to closures without obtaining pre-closure referral data for SRC, however it is possible to draw tentative inferences. An economic cost analysis of delayed disclosures of CSA, undertaken by the ISJC and SiT, found that the lifetime costs of CSA were very high, which could be minimised by working more effectively with specialist providers (Adisa, Hermolle & Ellis, 2023). Chronic and systemic underfunding of support services is a pressing issue that severely hampers service providers' ability to function effectively. Maintaining knowledge of the support service provision landscape is crucial to ensure referral efficacy but is lost when limited funding generates job insecurity and therefore high staff turnover. Short-term, competitive funding and insecure contracts threaten the sustainability of support services, affecting staffing, recruitment, retention and service consistency. Nationally, many support services are overwhelmed and the lack of time, consistent funding and staff to support the numbers of victim-survivors requiring help is limited (Widanaralalage et al., 2024; Madoc-Jones, Hughes & Humphries, 2015). A notable exception to this in Suffolk is the OPCC, which now makes multi-year grants funding VCSEs, making a positive difference to the uncertain landscape.

Factors affecting access to support include the disproportionate impact on women and vulnerable groups such as children, people with disabilities, those in care, and the LGBTQIA+ community. Additionally, there is pressure on families, care givers and third parties to support victim-survivors. Sexual violence can have long-term impacts on victim-survivors, including physical, emotional and economic consequences. Services such as Restitute offer resources and support to families and caregivers, to mitigate against future challenges and on-going trauma (Finch and McCulloch, 2025). Costs associated with sexual violence extend to lost economic output, criminal justice processes and increased demand on healthcare support (ONS, 2022). Societal costs in England and Wales, measured in anticipation, as a consequence, or as a result of, crime, are highest for supporting victims of violent crimes, which includes rape and violent injury, due to the high physical and emotional cost to the victim (Heeks et al., 2018).

Research Questions

The overall objective was to map current sexual violence service provision in Suffolk, identifying gaps and duplications, highlighting good practices and offering recommendations to inform future strategic and commissioning directions. The scope of this review covered all ages, all victims and all types of sexual violence (including non-recent and child sexual abuse) and to explore the vast range of sexual offences across Suffolk. The following research questions (RQ) informed the research design:

RQ1: What does support for survivors of sexual violence/offences look like in Suffolk? Where are the gaps and where are the overlaps?

RQ2: What do sexual violence survivors, practitioners and commissioners across Suffolk understand the strengths and limitations of sexual violence service provision to be?

RQ3: What are the potential benefits of effective sexual violence service provision? How can different models of service provision deliver integrated/place-based systems of support for survivors with varying needs?

RQ4: How are sexual violence services commissioned in Suffolk and elsewhere in the United Kingdom?

RQ5: What might effective commissioning in Suffolk look like?

Methods

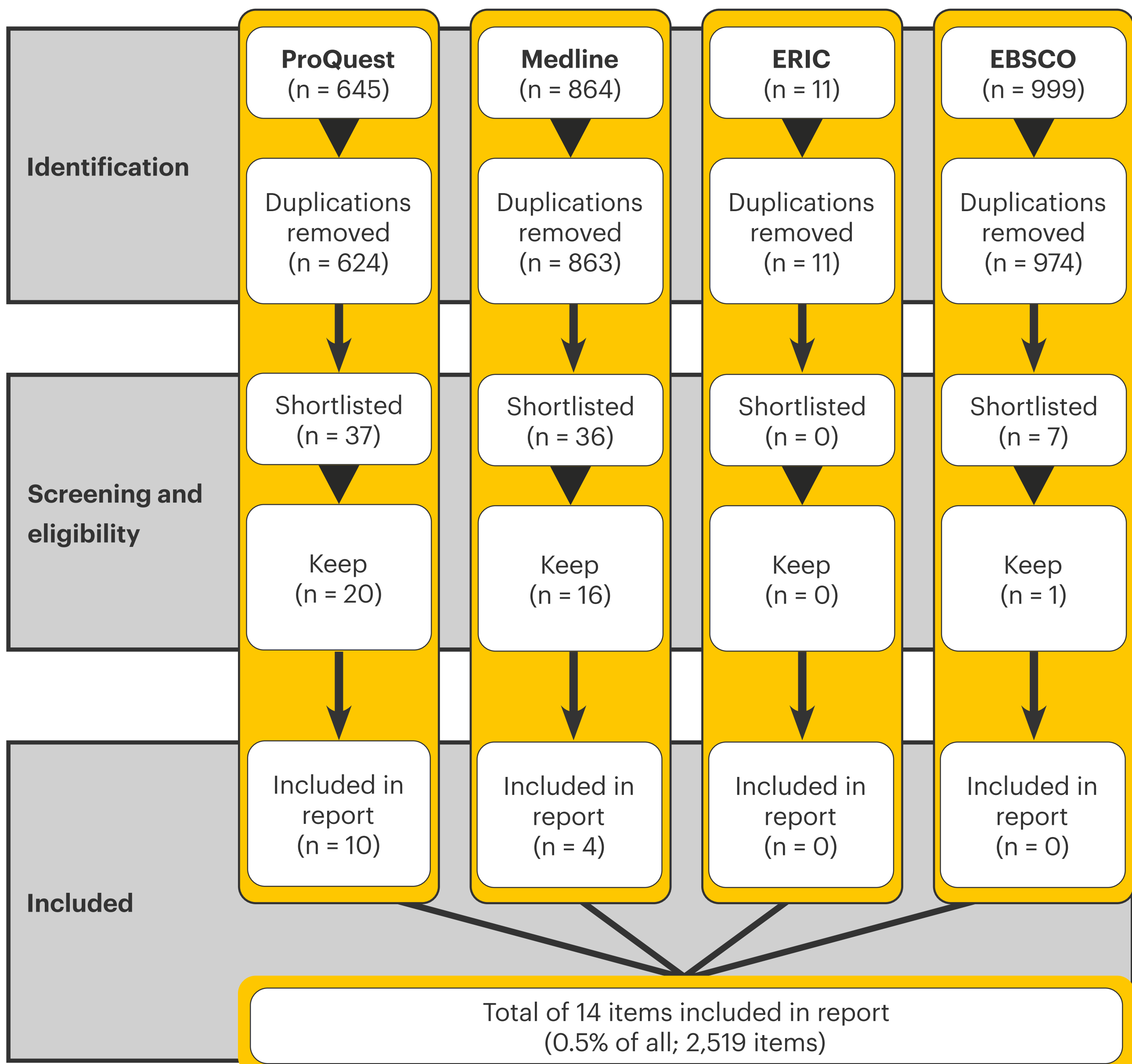
A mixed-methods approach was used including:

1) **Desk-based research (secondary data collection)**

   a) **A scoping review of academic literature**

   A total of 2,519 items were extracted from four databases. Figure 1 below depicts our procedure for screening items for eligibility, which resulted in the selection of 14 of the original 2,519 items (0.5%), selected for their relevance to the research questions. Items included are from peer-reviewed case studies or evaluations of UK-based services in **Appendix A**.

Figure 2. Flow diagram illustrating search strategy for eligibility for inclusion of academic papers in the literature review.



Items extracted from four databases collated, duplications removed and then shortlisted according to title and/or abstract. "Kept" items in the screening processes were then added to our database, where they were either (1) retained for their direct relevance and included in Table 1 (**Appendix A**), or (2) retained for contextual relevance, i.e., US-based studies.

b) A scoping review of the definitions and language of sexual violence terminology

Publicly available, online, local and national sexual violence strategy and policy documents were reviewed to examine the use of language and terminology. Thirty documents were searched for 50 sexual violence related key words and phrases, and analysed for overlap, interchangeable use, and whether or what definitions were given.

c) Collation and analysis of existing stakeholder data

2) A public call for evidence (primary data collection)

The public call for evidence for people affected by sexual violence was designed to address the second research question for the project, identifying how people within Suffolk who have experienced sexual violence (including third party victims) perceive local provision, and what they envision an ideal local service to look like.

The corresponding surveys for, and interviews with, professionals and commissioners also addressed the second research question, providing additional information by 'triangulating' (or enabling for cross-comparison with) the victim-survivor survey. This provided valuable additional context for some findings from the victim-survivor survey, and amplified findings about key issues. The victim-survivor survey provided rich qualitative data grounded in participants' lived experiences related to sexual violence, disclosure and help seeking. A vital part of the victim-survivor experience with service providers is feeling heard, believed and respected. Listening to victim-survivors and receiving support at the earliest opportunity gives them the best opportunity to deal with the consequences of their experience and trauma (Bond, Ellis and McCusker, 2018).

Researchers aimed to hear from up to 60 participants across victim-survivor, professional and funder commissioner surveys, with approximately 20 from each participant group. The research team exceeded this figure, receiving a total of 74 responses across the three surveys (see following section for breakdown by participant group). Each survey yielded in-depth insights about the perspectives and experiences of respondents.

The research team decided to elicit responses via anonymous surveys to facilitate safe and confidential participation by a range of informants, including those for whom methods such as interviews or focus groups could prove less accessible (i.e., neurodivergent victim-survivors or those with additional access or support needs). The qualitative data from the surveys and interviews were analysed using thematic analysis, and members of the research team worked both independently and collaboratively, to gain agreement on the topics for inclusion in our findings.

a) Online surveys from victim-survivors of sexual violence, providers of sexual violence services and commissioners/funders

Three separate surveys were deployed for people affected by sexual violence (including third party victims), professionals and commissioners. The surveys included optional demographic/professional sector and background questions, and four open-ended survey

questions to elicit free text submissions on key topics. The survey for professionals and commissioners included an option to securely submit top-level anonymised service user data (1c above). Thirty-nine victim-survivors completed the survey, with 37 providing substantive responses to the open-ended questions. Thirty-two professionals and five funder commissioners also responded with substantive responses. Of the professionals who took part in the call for evidence survey, the majority worked with victim-survivors in either supportive or investigative roles.

b) **Bespoke, purposive interviews, with service providers and commissioners**

Gaps in knowledge from survey responses were addressed with bespoke interviews with commissioners and practitioners from Suffolk. Participants were identified through gatekeepers from the SCC, SNEE ICB and PCC and other relevant stakeholders, as well as a voluntary opt-in via the public call for evidence. Participants were provided with an information form, a consent form and given a specific point of contact at the University of Suffolk. The interviewees were under no obligation to take part and received a full briefing prior to the interview taking place. Eight people were interviewed, including six practitioners and two commissioners.

A note about call for evidence data

When interpreting and framing recommendations based on these qualitative findings, it should be noted that the call for evidence survey and interviews were designed to provide a detailed insight into the views of a small number of respondents, and to draw on these insights to strengthen and give additional dimension to the data gathered via other work strands, rather than to produce generalisable claims about the total population of victim-survivors, professionals and commissioners in Suffolk. These findings represent a snapshot of the wider local picture, capturing the thoughts and perspectives of a specific group of people at a particular point in time.

Data integration

All the information gathered from our data collection have been analysed to conduct a gap and overlap analysis of the research questions. We focused on the findings from the surveys and interviews to provide the themes for our research. The other strands of our data collection, the terminology/language, scoping reviews, and aggregated data, then provided additional layers to our findings and conclusions.

Ethics

A favourable review of the research was provided by the University of Suffolk (UoS) Research Ethics Committee (Ref: RETH24/028) before any data collection commenced. Data was stored on encrypted password computers, with security of storage a key priority. The University of Suffolk Data Governance team reviewed the request and confirmed that it met their requirements. Participants were provided with information sheets and were able to provide informed consent to their inclusion. Participant safety was paramount, and they were signposted to professional support via Survivors in Transition, if required.

Findings

Sexual violence terminology and the language used is important

Definitional blurring, overlap, and lack of clarity around sexual violence language in research, strategy and policy documents translates to provision and can impact on the ability of commissioners and service providers to deliver effective services. In turn, it can particularly cause confusion amongst victim-survivors, especially around understanding whether what has happened to them is sexual violence, which can have consequences for accessing support. Recent research in Suffolk found a lack of awareness amongst victimnsurvivors' understandings of both recognising themselves as victims of sexual violence crimes and the meanings of the terms themselves: '*The number of people who told us they would have not related to the term 'domestic abuse' at the start of them needing to access support'* (Ward & Puleston, 2025: 34).

In many documents reviewed, terminology related to sexual violence was not given a clear definition, or indeed any definition at all. For example, 'rape' was included in 26 out of 30 national and regional policies, which were publicly available. No definition was provided in 21 documents, while in four documents the term was included under other definitions, such as Violence Against Women and Girls, or Sexual Exploitation. Only one document included a full definition, a legal one outlined in the Sexual Offences Act (Legislation.gov.uk, 2003). Some blurring between terminology was found for example using terms such as 'acute'/'non-acute', 'recent'/'non-recent', or 'historic', interchangeably and without clear definition. Terms such as 'complainant'/'victim'/'survivor'/'victim-survivor', or 'offender'/'suspect'/'perpetrator' were often used interchangeably, with few agreed upon definitions — in regards to victim terms, some aligned with the Victim's Code (Ministry of Justice, 2020) or the Victims and Prisoners Act (Legislation.gov.uk, 2024), while others preferred their own alignment.

Other documents, such as the VAWG Commissioning Toolkit (Home Office, 2022) specified that the terms were used interchangeably. The perpetrator terms, while they were rarely defined, had very similar definitions. Many terms were included under the umbrella of other terms and definitions. For example, in two documents, sexual abuse was included under a definition of domestic abuse, despite the two often being separate offences and with separate issues. Similarly, some specialised and newer terms such as 'up skirting' were often either left undefined or placed under the broad definition of Violence Against Women and Girls.

These findings underpinned our approach to analysis and **Recommendation 2** of this report, that terminology and language must be clearly defined in policy, practice and communication with service users and the public and should be co-produced and clearly defined, so it can be understood by all. Suffolk can lead the way on this in the next VAWG strategy.

In this report the findings from both our primary data (surveys and interviews) and secondary data (scoping reviews for literature and terminology and language) are presented together under each research question. Whilst this report set out to elicit responses from minoritised groups, the small volume of responses from this group suggests much more work is needed to hear the experiences of these groups. A key aspect of this report is the importance of victim-voice and the need for further work encompassing victim-survivor lived experience. **Recommendation 7** suggests the sector would benefit from data in respect of those who identify as male and minoritised groups. These recommendations are consistent with the ones recently made by Ward and Puleston (2025) who also conducted research in Suffolk.

A 'Suffolk language guide' would be beneficial for users of sexual violence services and would be worthy of a future piece of work. However, we do suggest a clear definition of 'sexual violence' is required immediately. As a result of our analysis of currently used definitions, we synthesised the following concise and lay-friendly definition (with optional links to more detailed and behaviourally specific definitions, per the examples in **Appendix D**):

> *Sexual violence means unwanted sexual behaviour that happens against a person's will. It may involve physical force or violence or, more commonly, other forms of coercion (pressure), including threats, manipulation or power over the affected person.*

We note that there are intrinsic trade-offs when crafting a definition of sexual violence, which entail weighing important, but at times competing considerations around clarity/ descriptiveness, readability and brevity. Any definition should be trauma-informed (for example, highly detailed definitions may be more readily understandable in relation to specific lived experiences but may be experienced as more visceral or distressing). Additional consultation with victim-survivors and professionals could support the accessibility and acceptability of the proposed definition and inform the development of an easy read definition to promote wider accessibility for children and young people, people with learning difficulties and people with learning disabilities.

RQ1: What does support for survivors of sexual violence/offences look like in Suffolk? Where are the gaps and where are the overlaps?

A note about aggregate data

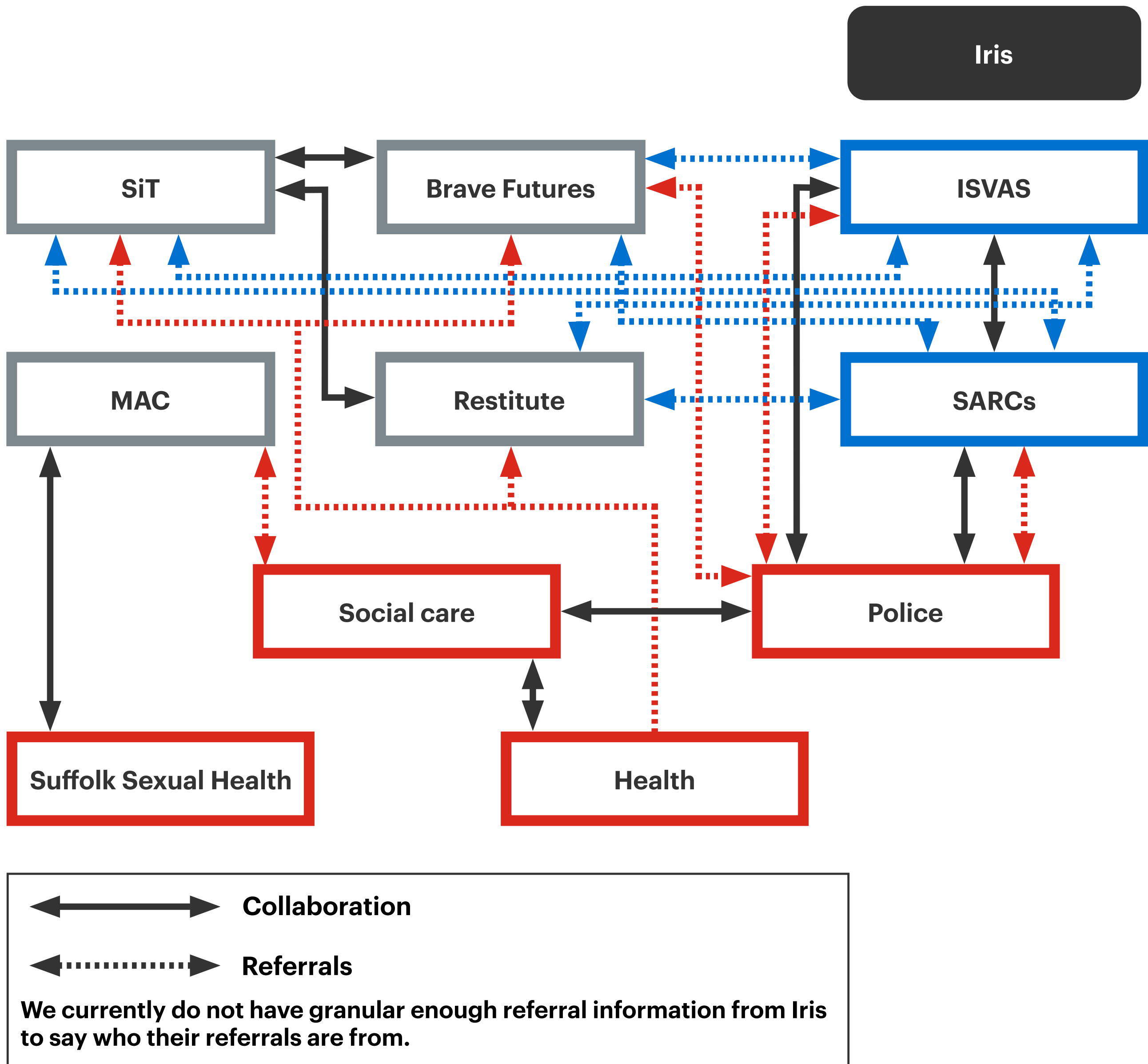
Seven organisations provided aggregate data for their services. Due to the inconsistent nature of recording within and between organisations, and no standardised method of reporting across the system, much is incomplete or missing, and a lot is recorded and aggregated differently to other services. There is also a wider issue relating to a 'golden thread' of provision for a victim/survivor as they move through services. If their information is recorded in one way in one service, and a different way — or not at all — in another, their needs may not be fully met, and they may drop out of the system. Thus **Recommendation 7** calls for a robust and consistent approach to the accurate collection and recording of data. This will help victim-survivors on their journey through the services. A suggested template for data categories and classification systems is provided in **Appendix C**. There are eight sexual violence specific services in Suffolk, as shown in Table 1, all of whom have slightly different provision remits. A larger table with further provision detail is available in **Appendix E**.

Table 1: Table of sexual violence specific referral services available in Suffolk.

Service	Provision
Brave Futures	Specialist voluntary support service for children of sexual abuse
Independent Sexual Violence Advisor (ISVA)	Support for victim-survivors through the criminal justice process
IRIS	Community sexual assault service for people who have experienced sexual violence
Make a Change	Specialist voluntary community outreach for those concerned about harmful behaviour of themselves, (ex-)partners, friends, families or professionals
Restitute	Specialist voluntary support for third party victims of crime, including parents, careers, children, friends or partners
Sexual Assault Referral Centres (SARC)	Specialist medical and forensic services for anyone who is a victim of sexual abuse
Suffolk Sexual Health	Local authority funded sexual health services across Suffolk
Survivors in Transition (SiT)	Specialist voluntary support for survivors of all ages and gender who have experienced sexual violence or sexual abuse

Service providers shared their own referral pathways with us, which are captured in Figure 3 below. No information was available about referrals or collaborations from IRIS. There appears to be strong collaborative working between some of the services and several referral pathways between them, with professional interviewees describing their efforts to forge positive working relationships and open lines of communication. However, the picture is unclear as to the referral links between statutory and voluntary support. For example, there do not appear to be clear links between the health and social work system and service providers. A lack of collaboration in this space means victim-survivors face delays in accessing support, a viewpoint reflected by practitioners on local challenges and the demand for services. Additionally, issues in the wider criminal justice system create further delays and the possibility of re-traumatisation for victim-survivors.

Figure 3: Referrals and collaborations between services.



Referral and reporting data

Due to the inconsistent quality of the data, inferential statistical analysis was not possible. However, there are several notable observations that can be made from the table and following figures illustrating year-on-year referrals into services from different sources. Table 2 summarises the sources of referrals into organisations between 2022 and 2024.

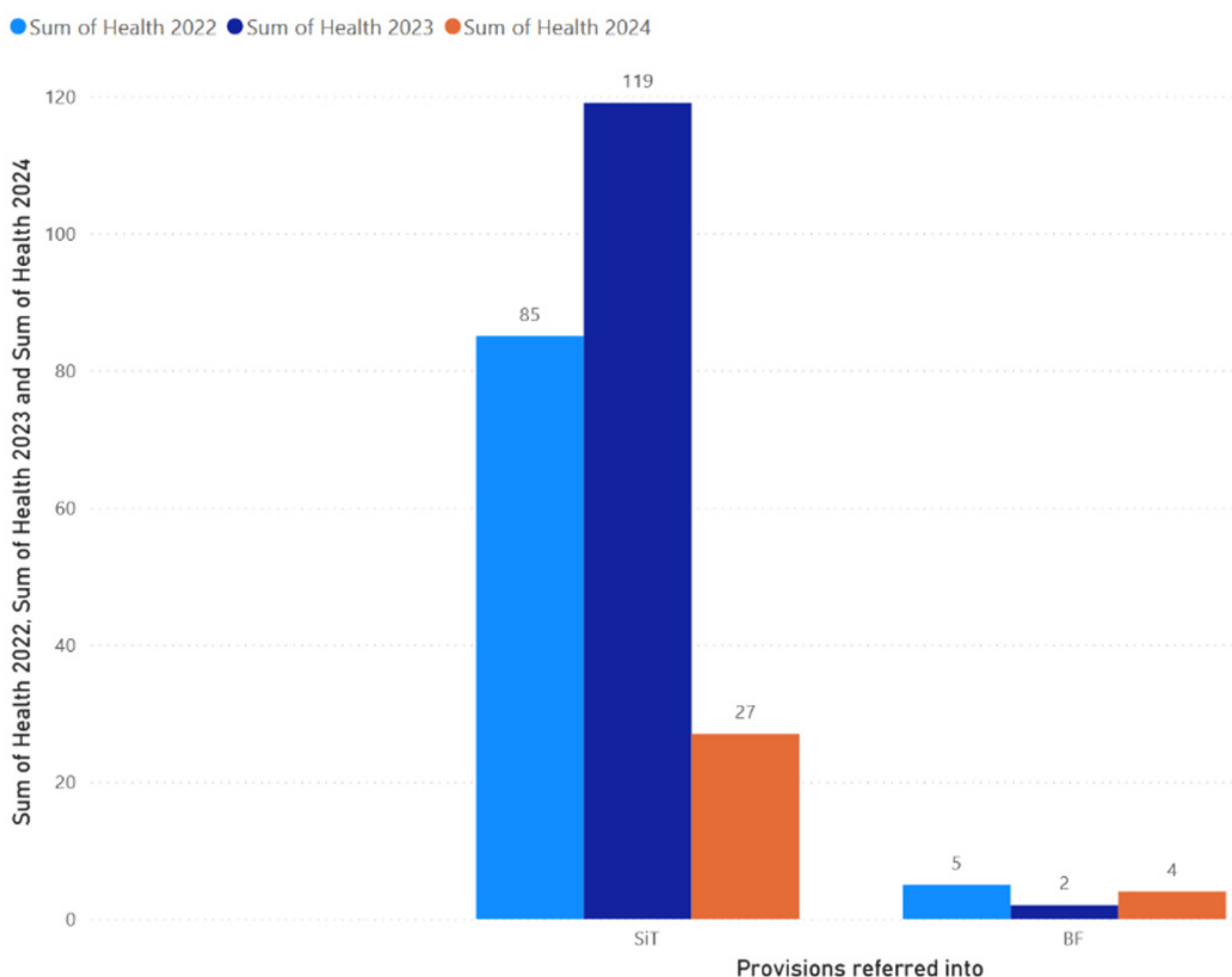
Table 2: Sources of referrals into organisations (2022–2024) [‘n/a’ denotes no data recorded].

Referrers						
Health* 2022	85	5	n/a	n/a	n/a	n/a
Health 2023	119	2	n/a	n/a	n/a	n/a
Health 2024	27	4	n/a	n/a	n/a	n/a
Health Total: 242	**231**	**11**	n/a	n/a	n/a	n/a
NSFT 2022	417	26	n/a	n/a	n/a	n/a
NSFT 2023	410	20	n/a	n/a	n/a	n/a
NSFT 2024	489	11	n/a	n/a	n/a	n/a
NSFT Total: 1,373	**1,316**	**57**	n/a	n/a	n/a	n/a
Police 2022	4	5	n/a	173	453	n/a
Police 2023	6	3	n/a	137	473	n/a
Police 2024	11	3	n/a	163	430	n/a
Police Total: 1,861	**21**	**11**	n/a	**473**	**1,356**	n/a
SARC / ISVA 2022	136	39	n/a	n/a	n/a	n/a
SARC / ISVA 2023	282	20	n/a	n/a	n/a	n/a
SARC / ISVA 2024	354	54	n/a	n/a	n/a	n/a
SARC/ISVA Total: 885	**772**	**113**	n/a	n/a	n/a	n/a
SCC ACS 2022	6	n/a	n/a	n/a	n/a	n/a
SCC ACS 2023	12	n/a	n/a	n/a	n/a	n/a
SCC ACS 2024	10	n/a	n/a	n/a	n/a	n/a
SCC ACS Total: 28	**28**	n/a	n/a	n/a	n/a	n/a
SCC CYP 2022	8	45	n/a	n/a	n/a	n/a
SCC CYP 2023	7	31	n/a	n/a	n/a	n/a
SCC CYP 2024	10	37	n/a	n/a	n/a	n/a
SCC CYP Total: 138	**25**	**113**	n/a	n/a	n/a	n/a
Education 2022	n/a	18	n/a	n/a	n/a	n/a
Education 2023	n/a	22	n/a	n/a	n/a	n/a
Education 2024	n/a	25	n/a	n/a	n/a	n/a
Education Total: 65	n/a	**65**	n/a	n/a	n/a	n/a
Self 2022	82	0	98	90	47	n/a
Self 2023	72	8	84	95	54	n/a
Self 2024	66	23	70	147	38	15
Self Total: 989	**220**	**31**	**252**	**332**	**139**	**15**
Other 2022	64	26	14	71	56	n/a
Other 2023	87	20	34	70	60	n/a
Other 2024	137	25	51	53	114	25
Other Total: 907	**288**	**71**	**99**	**194**	**230**	**25**

* Notes: **Health** includes GPs, hospitals, etc. **NSFT** includes all mental health referrals, Integrated Delivery Team, Crisis, 111 option 2, Access and Assessment Team, Wellbeing, CMHT, etc. **Other** includes internal, other organisations, re-referrals, DA, NSVC, substance use, probation.

Only SiT and Brave Futures provided referral data from health sources (Figure 4 below). Comparatively, SiT took the highest number of referrals here, with the largest number in 2023 at 119 referrals, and a notable drop in 2024 to 27 referrals. Brave Futures takes a small number of referrals from health sources, five and under per year.

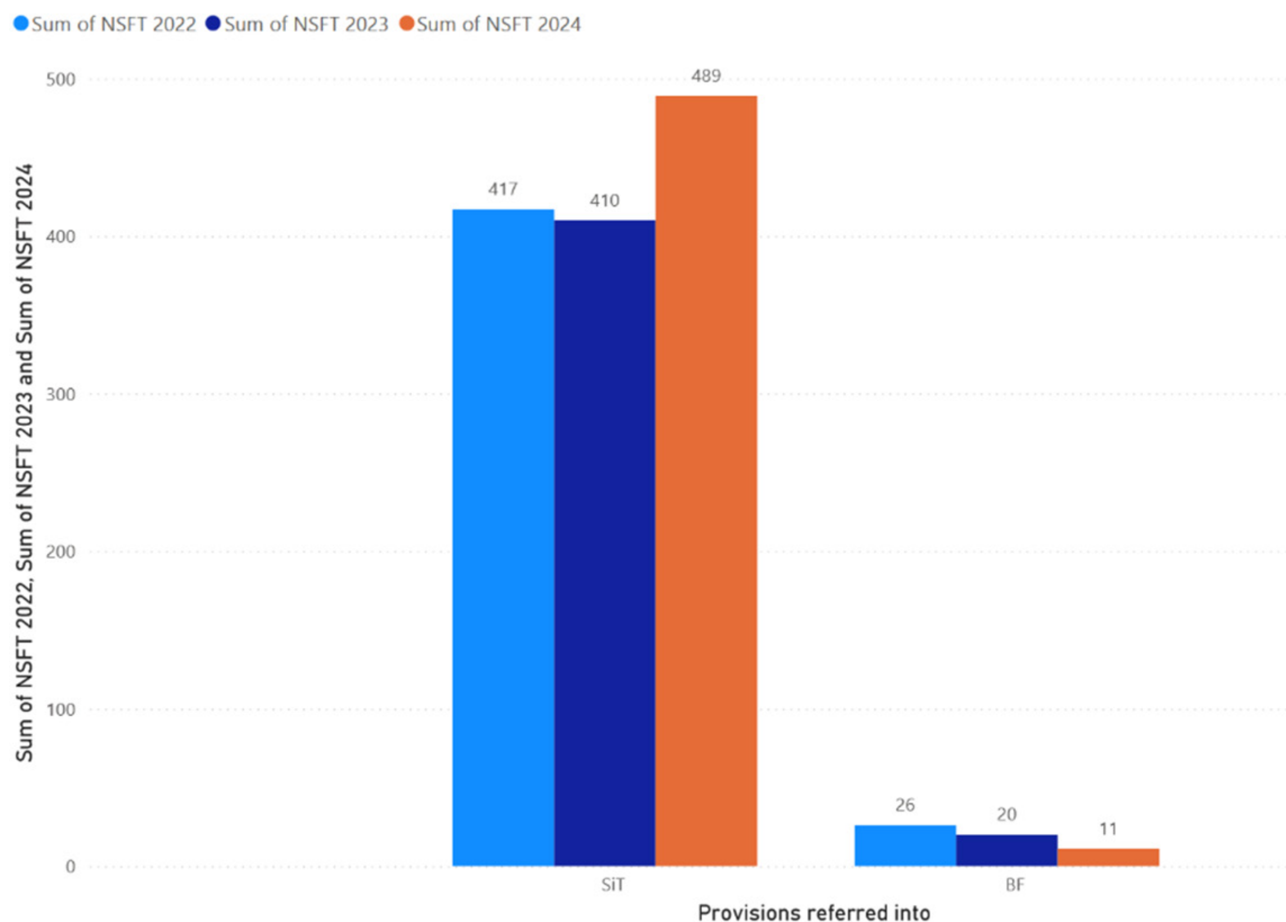
Figure 4: Referrals from health sources.



Provisions referred into	Health 2022	Health 2023	Health 2024
SiT	85	119	27
Brave Futures	5	2	4

Figure 5 below shows referrals from NSFT and gives a similar picture to the health referrals; apart from SiT experiencing a large increase in referrals (from 410 in 2023 to 489 in 2024) from NSFT, which did not occur in the health referrals. It is possible that the rise in NSFT referrals is related to the drop in health referrals — for example, a change in how the data was recorded or in where victim/survivors were more likely to be referred from — but this is not definite. Brave Futures show a year-on-year drop in referrals from NSFT sources.

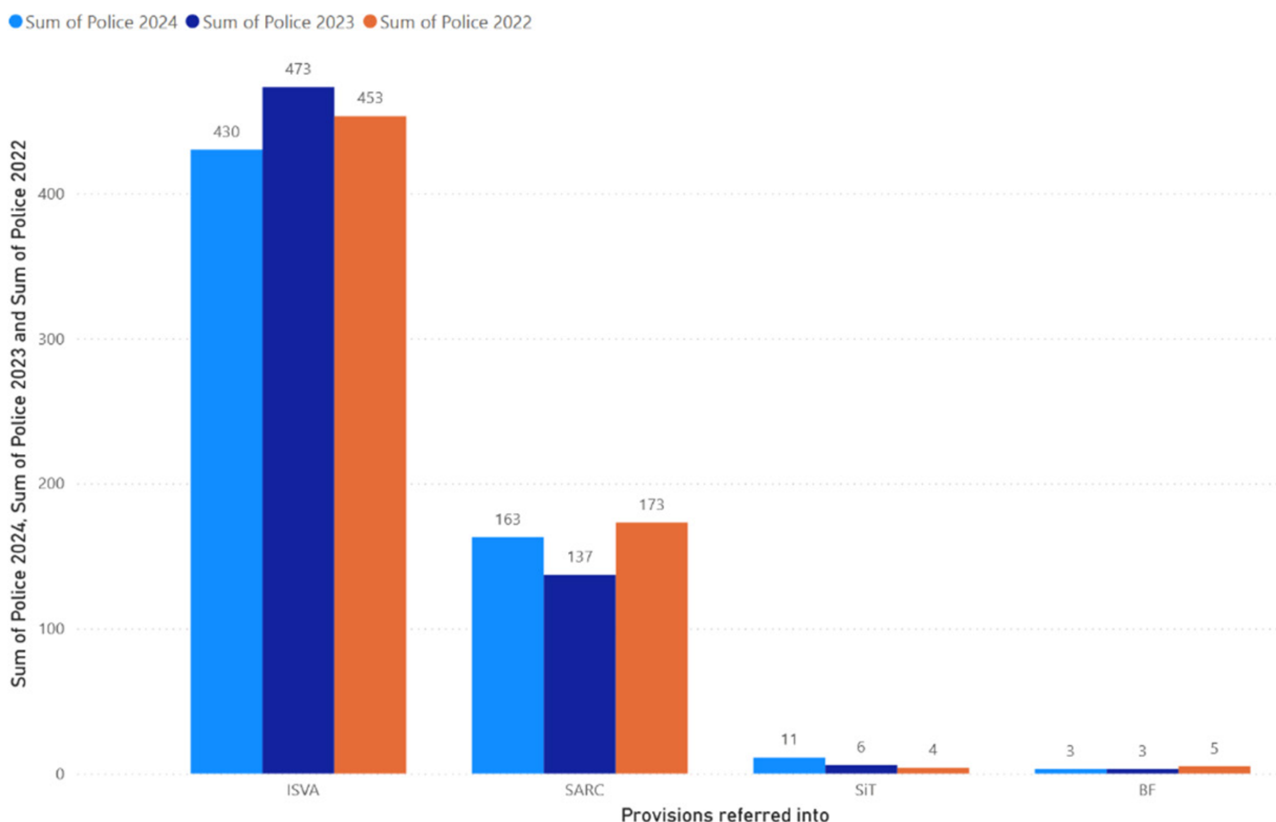
Figure 5: Referrals from NSFT sources.



Provisions referred into	NSFT 2022	NSFT 2023	NSFT 2024
SiT	417	410	489
Brave Futures	26	20	11

As can be seen in Figure 6 below, ISVAs, who sit with the police and work closely with them, and SARCs, understandably had the higher referral rates from police. SARCs do provide a service for those who do not wish to officially report. SiT, who receive a high overall rate of referrals have a low police referral rate: this is likely because of the often-historical nature of the abuse for which SiT provides support. Brave Futures also had few referrals from police; 11 of 472 total referrals across all three years, which is notable as one of the criteria for support from Brave Futures is that the SV must have been reported to the police and/or the children and young people (CYP) service. It is likely that due to this choice, more victim/survivors or their families opt to go through the CYP service to report.

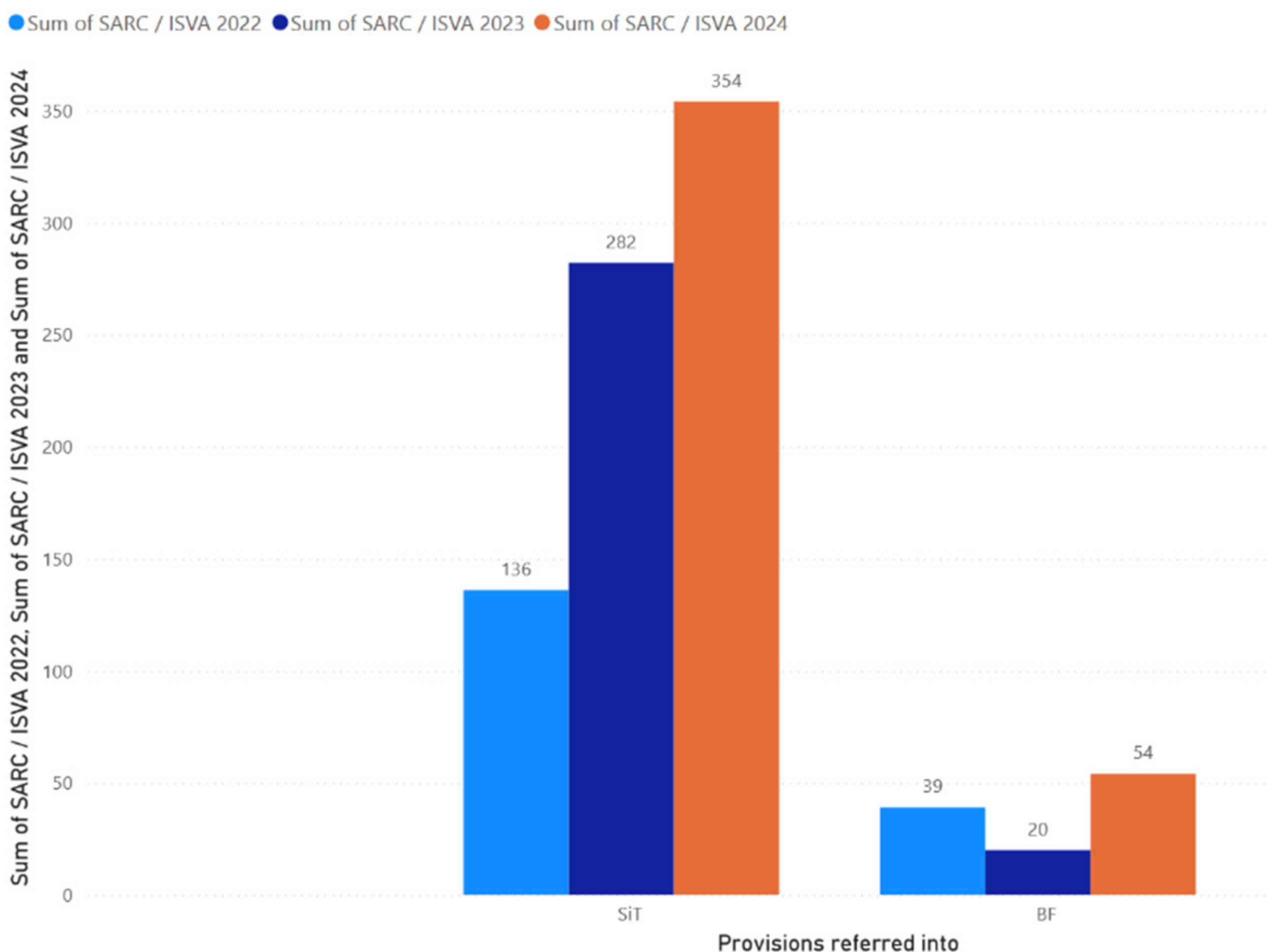
Figure 6: Referrals from police.



Provisions referred into	Police 2022	Police 2023	Police 2024
SiT	4	6	11
Brave Futures	5	3	3

Figure 7 below shows that there was a year-on-year increase of referrals into SiT from SARCs and ISVAs, and the referral numbers in 2024 more than doubled since 2021. Brave Futures also show a jump to 54 referrals in 2024, which is proportionally a large amount, as their total referrals from all sources in 2024 was 182. SiT and Brave Futures were the only services who recorded SARC/ISVA referrals.

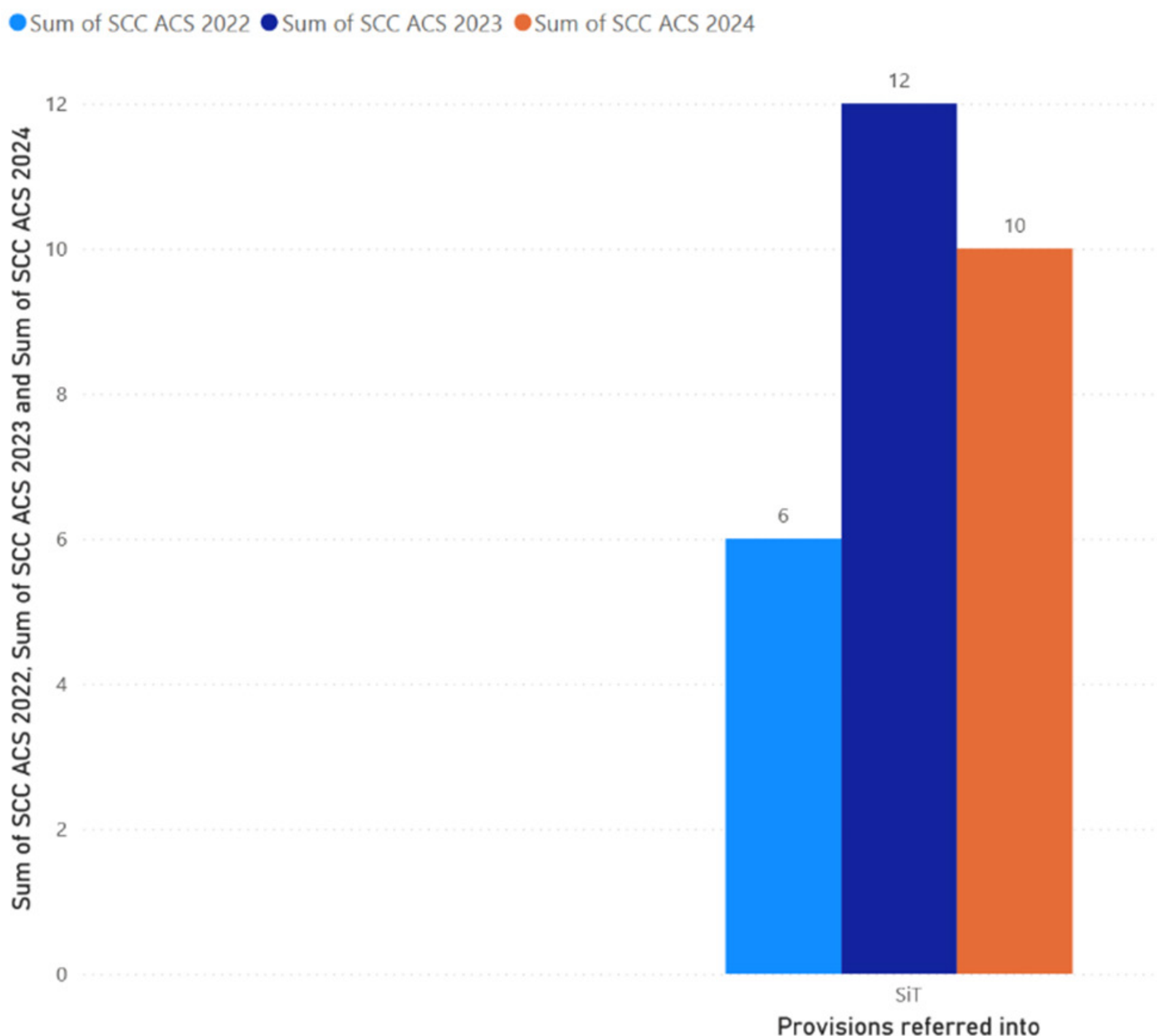
Figure 7: Referrals from SARC/ISVAs.



Provisions referred into	SARC/ISVA 2022	SARC/ISVA 2023	SARC/ISVA 2024
SiT	136	282	354
Brave Futures	39	20	54

SiT was the only service recording adult social care referrals, and these were a comparatively small amount: 28 across all three years, while SiT's total referrals for all three years were 2,901. It is likely that statutory adult referrals are more likely to come from other sources such as health and NSFT.

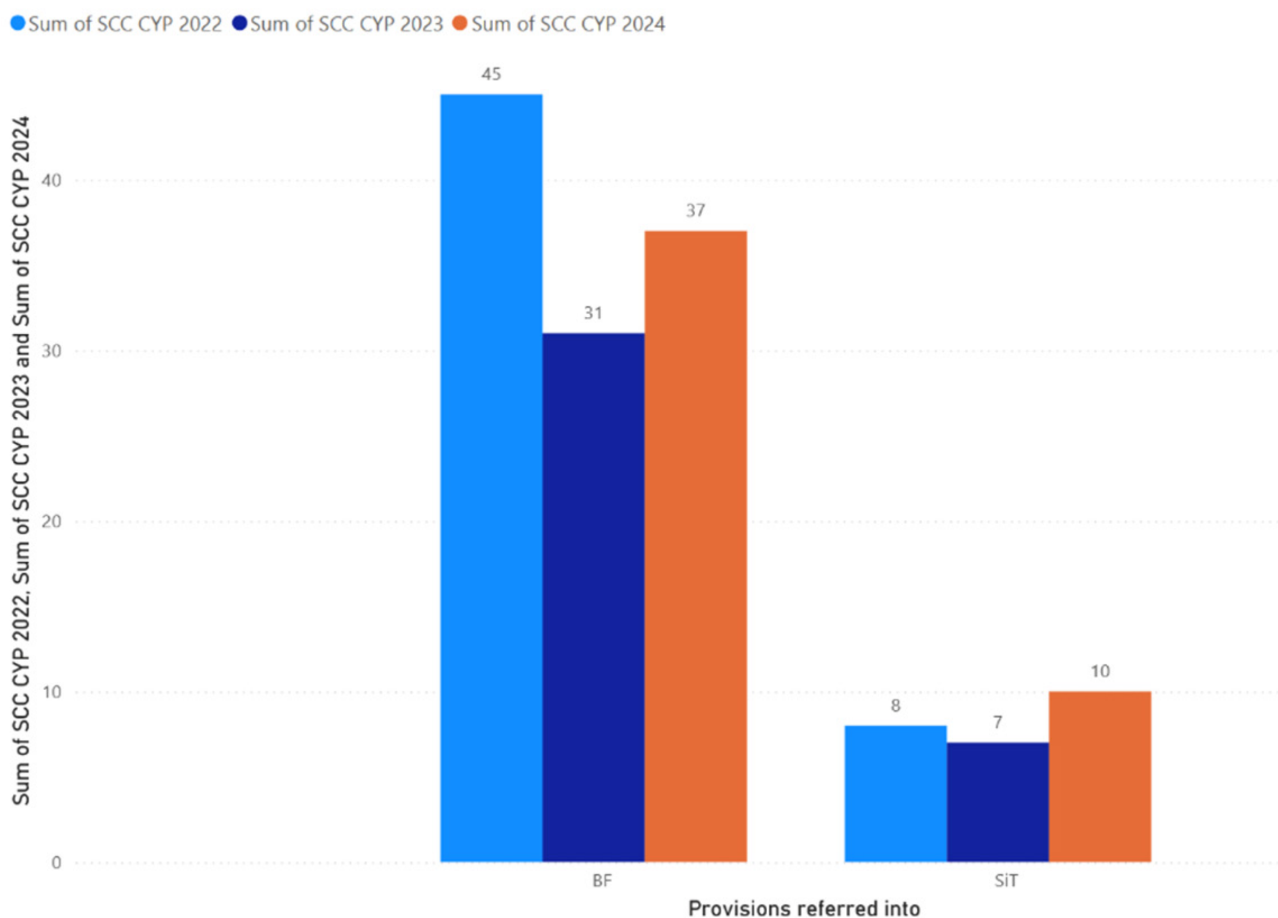
Figure 8: Referrals from adult social care.



Provisions referred into	SCC ACS 2022	SCC ACS 2023	SCC ACS 2024
SiT	6	12	10

Similarly to other referral sources, SiT and Brave Futures were the only providers recording data for CYP service referrals. Figure 9 shows the two providers' referral rate changes are similar, with a drop in 2023 and a slight rise in referrals in 2024. CYP referrals are notably proportionately high for Brave Futures — 113 across all years out of 472 total — which appears to be in line with the suggestion in Figure 5 (police) that victim/survivors and families may prefer not to report to the police, but to CYP services.

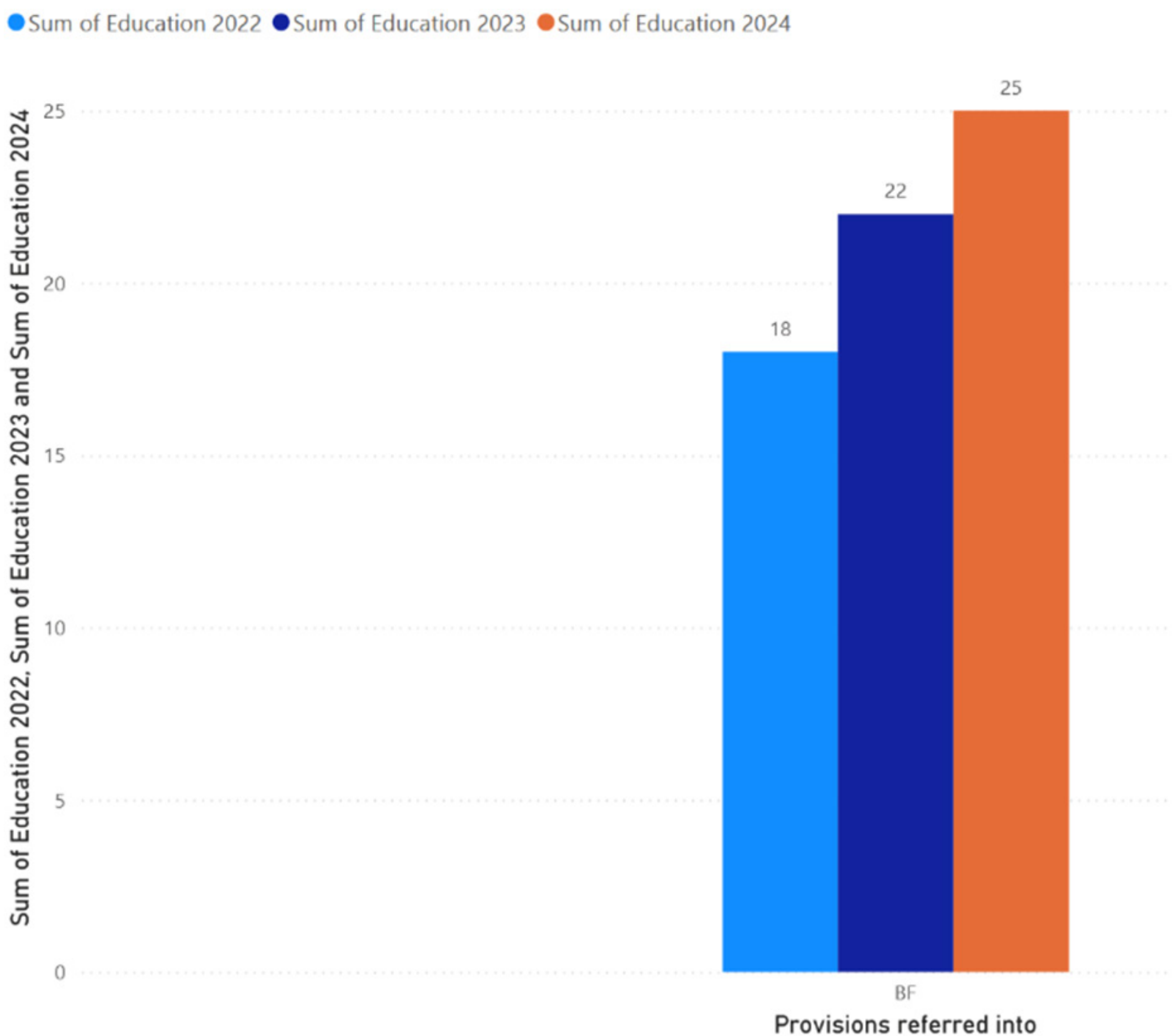
Figure 9: Referrals from Children and Young People services.



Provisions referred into	SCC CYP 2022	SCC CYP 2023	SCC CYP 2024
SiT	8	7	10
Brave Futures	45	31	37

Brave Futures were the only provision recording educational referrals, and these comprised a relatively high number of total referrals: 65 across all three years out of 472 total referrals (see Figure 10). There is also an increase year-on-year in referrals from this source, suggesting that more educators are referring, which could mean more CYP are disclosing, there is more awareness around sexual violence, or that incidences are rising, which could be placed in context with increasing understanding of peer-on-peer abuse and online harms.

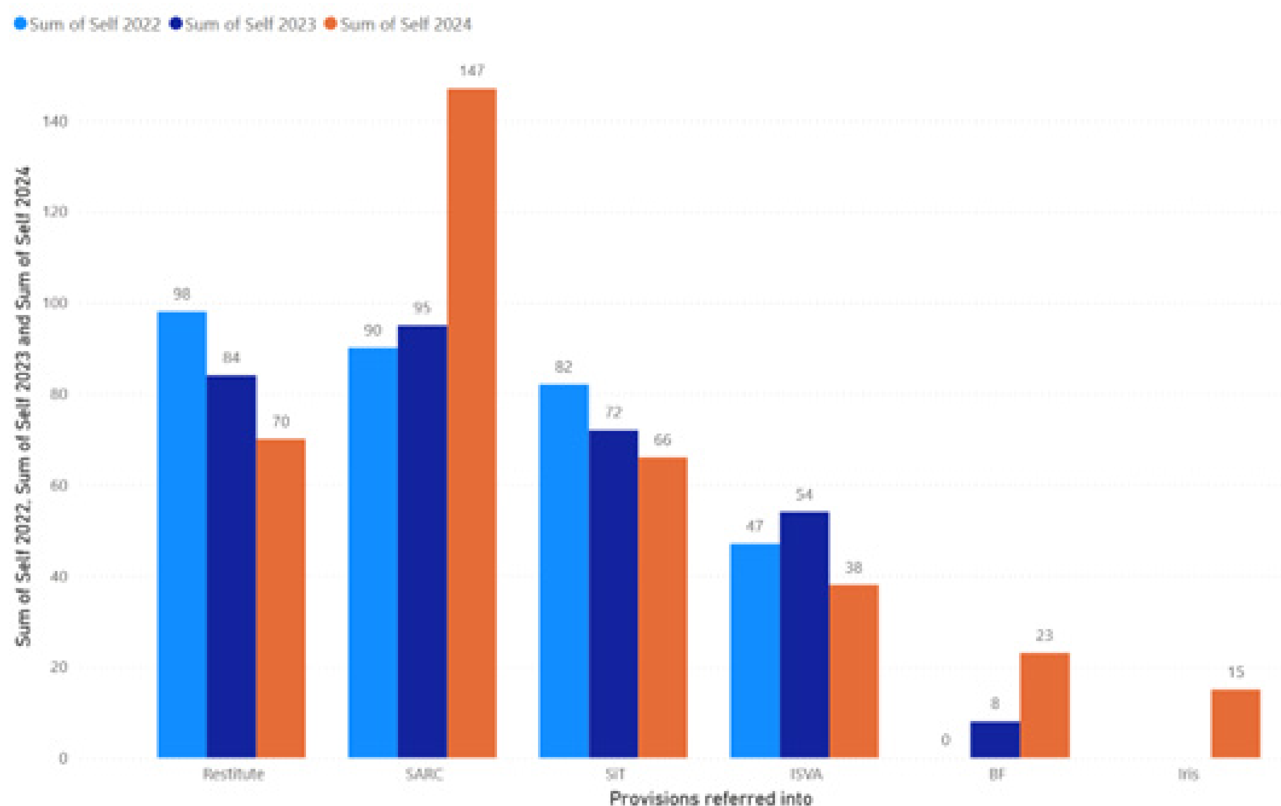
Figure 10: Referrals from education.



Provisions referred into	Education 2022	Education 2023	Education 2024
Brave Futures	18	22	25

All services recorded self-referral data (Figure 11). For Restitute and SiT, there is a year-on-year decrease in self-referrals, while for SARCs and Brave Futures, a year-on-year increase. Iris, a new provision, has only 2024 data, and 15 of its 40 total referrals were self-referrals. Notably, there is a large jump from 95 in 2023 to 147 in 2024 for the SARC service. There may be several possible factors contributing to this, including a potential change in the way data is recorded or a rise in awareness of the SARC and its offer. There is a matching drop from 2022 and 2023 to 2024 in other referrals, which may point to a change in information recording.

Figure 11: Self referrals.



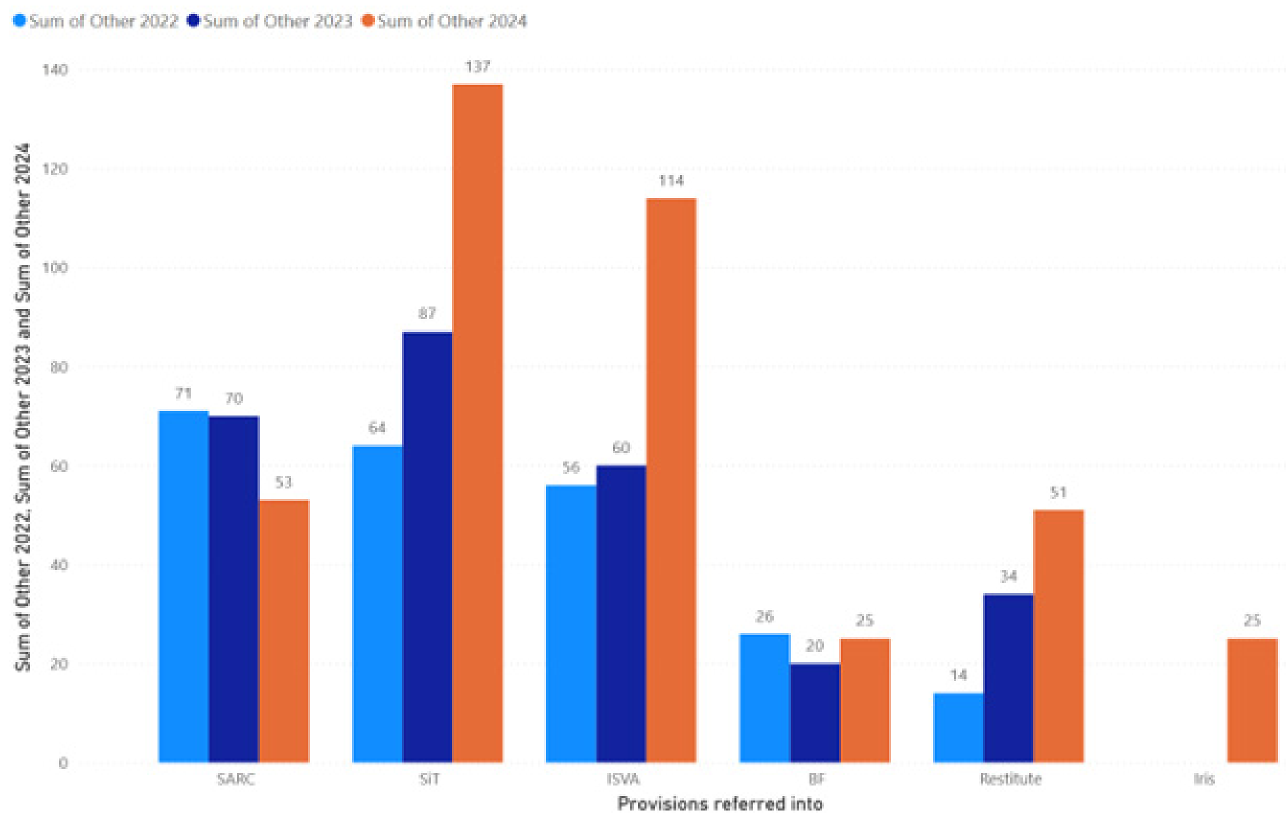
Provisions referred into	Self 2022	Self 2023	Self 2024
SiT	82	72	66
Brave Futures	0	8	23
Restitute	98	84	70
SARC	90	95	147
ISVA	47	54	38
Iris	0	0	15

Figure 12 below shows SiT and ISVAs had a notable increase in 'other' referrals, which can include internal referrals, other organisations, re-referrals, domestic abuse referrals, Norfolk and Suffolk Victim Care, substance use support, and probation. Conversely, the SARC shows a drop from 71 and 70 in 2022–2023 respectively to 53 in 2024, which may match the large rise in their self-referrals. Restitute show a year-on-year increase in these referrals, while Iris had 25 out of their 40 total referrals in this category. There are several possible factors causing these changes, including more awareness by these other services of the specialist providers, changes in data recording requirements, or a genuine change in incidence patterns.

Norfolk and Suffolk Victim Support (NSVC), counted under other referrals, do not provide specific SV services but do take a high number of SV referrals per year, including serious sexual violence such as rape: 3,821 total across all three years for Suffolk. However, out of all SV services, only SiT has recorded referrals from NSVC, and counts only six. Thus, there are many victim/survivors from NSVC who may be dropping out of the system and not being referred onto specialist services — thus the 'golden thread' of data and provision between services for a victim survivor is missing.

Please see Figure 12 on Page 29 for the corresponding data.

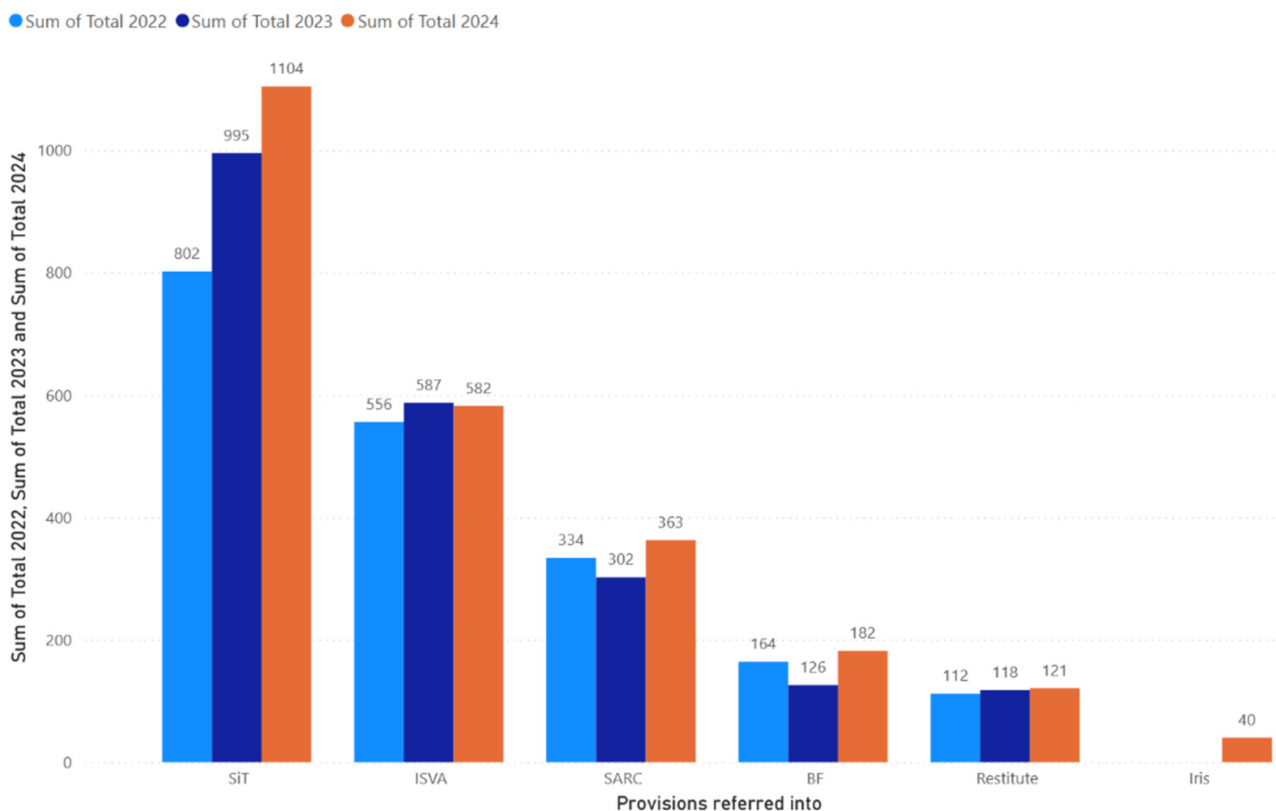
Figure 12: Referrals from other sources.



Provisions referred into	Other 2022	Other 2023	Other 2024
SiT	64	87	137
Brave Futures	26	20	25
Restitute	14	34	51
SARC	71	70	53
ISVA	56	60	114
Iris	0	0	25

Figure 13 below illustrates the total number of referrals per year. We can see that SiT receive the highest volume of referrals across all services and have seen a large year-on-year increase overall. The rest, with the exception of Iris who are a new service provider, have remained relatively stable in terms of referrals into the services, although there have been overall increases across the system.

Figure 13: Total referrals year-on-year.



Provisions referred into	Total 2022	Total 2023	Total 2024
SiT	802	995	1,104
Brave Futures	164	126	182
Restitute	112	118	121
SARC	334	302	363
ISVA	556	587	582
Iris	0	0	25

In relation to the Criminal Justice System (CJS) in Suffolk, there is still a large disparity between rape reports and convictions. Between 2021 and 2024 inclusive, 2,901 rapes were reported to the police, with 69 total convictions. This disparity was at its greatest in 2022–2023, where there were 1,562 reported rapes and 17 convictions. This is likely related to the CPS backlog (locally, some have waited five to eight years for trial), which has a detrimental impact on victim/survivors. Ward and Puleston (2025) concur that the delays in the CJS system have had considerable impact on local services and victim-survivors themselves in Suffolk.

It is important to note that the police receive a high volume of reports each year for sexual violence. However, while referrals to ISVAs and SARCs are high, overall total referrals from police are low: 635 referrals to all services that provided data in 2022, 619 in 2023, and 607 in 2024, a total of 1,861 across all three years. This is a markedly low number, considering all types of sexual violence that are reported to police.

Referral source data was recorded differently for each organisation, with different levels of granularity and varying terminology — three organisations provided two or three high level sources, while three organisations provided 10–12 more granular sources. This made it difficult to draw robust conclusions about where any gaps are in who is or is not referring to these services. However, where recorded, aside from one service which only recorded 'self' and 'professional', police appeared to consistently to refer into all services, the highest for these being ISVAs (1,356), and self-referrals were consistently recorded for all organisations, the highest for these being SiT (620).

Waiting times for services

Table 3 shows a variety of waiting times for victim/survivors, as well as intervention lengths. Notably, the two providers who recorded referral to initial contact have a short time from referral to initial contact, indicating a positive and proactive approach to ensure victim/survivors are not left uncertain about their referral. Iris also has a very short waiting time for interventions currently, however they are a new service — referrals are relatively low at present thus capacity may be able to match demand. SiT, Brave Futures, and Restitute have a one to two month wait from contact to intervention, which may seem considerable, however the CSA Centre found in 2024 that nationally there was an average six months wait time for support, with a 'postcode lottery' of provision (Centre of Expertise on Child Sexual Abuse, 2024). This suggests that Suffolk is doing well in terms of keeping waiting times as low as possible given resource restrictions and increasing demand, and ensuring contact as early as possible after referral, even if victim/survivors need to wait some time for intervention, is a trauma-informed way to approach this.

Table 3: Waiting times and intervention lengths.

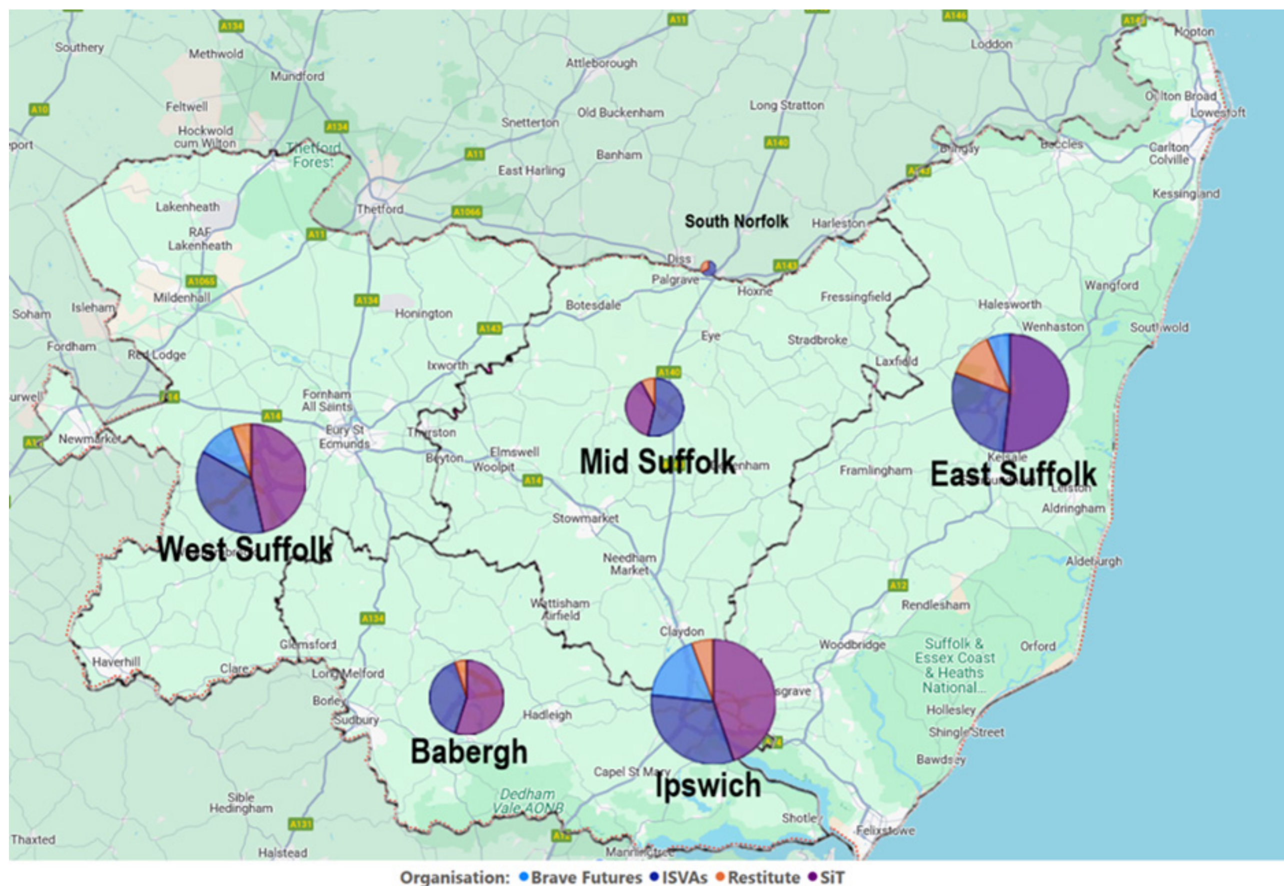
Average waiting times:	SiT	Brave Futures	Restitute	Iris
Referral to initial contact	1.6 days	-	-	3 days
Contact to intervention start	31 days	60 days	60 days	5 days
Length of intervention	26 sessions	25 sessions (but flexible)	as long as needed	12 weeks

Geographic data

Geographic data was further aggregated into districts for consistency as organisations provided different levels of granularity. Only four out of seven services gave geographic data. As can be seen in Figure 13, the data indicates that the highest number of referrals come from Ipswich (1,492 referrals) and West Suffolk (1,121 referrals). Ipswich is the main hub for most services, so this is expected, while West Suffolk is a large area which includes the county town of Bury St Edmunds, and the towns of Newmarket, Brandon, Mildenhall, and other referral locations. The lowest referral locations include South Norfolk (15 referrals) — these referrals were from Diss and Wymondham; and East Suffolk (84), which may be due to specific referral information for some districts not being provided by Survivors in Transition and Brave Futures. Restitute and the ISVA service were the only services who provided a breakdown of towns and villages, and based on this information, by far the highest number of referrals for both services came from Lowestoft. Lowestoft is on the Suffolk coast, one of the most deprived areas in the county. Despite most services being based in Ipswich, there is a wide spread of referrals, some as much as one hour and 17 minutes away by car and longer via public transport, suggesting that victim/survivors must often travel long distances to reach in person support. Some local services such as SiT provide hybrid support options, mitigating some of the practical challenges for rural victim-survivors seeking specialist support.

The global evidence base suggests that the increased availability of online support can improve access for some groups of victim-survivors, including those navigating "transportation, childcare [and] scheduling conflicts, language barriers, and safety and stigma concerns of accessing in-person services" (LeRoux et al, 2022: 11). However, there are also challenges and barriers associated with virtual provision which mean that it is not the best, preferred, or most accessible, option for all victim-survivors, including practical issues linked to a lack of access to affordable or reliable internet coverage or a lack of prior familiarity with the device or apps needed (Ghidei et al, 2023). Additionally, for victim-survivors experiencing technology-facilitated coercive control (including in a post-separation context), there may be heightened safety and privacy concerns linked to accessing online support (Harris & Woodlock, 2019). This body of literature also indicates that victim-survivor choice and agency is important in understanding the potential benefits and risks of hybrid provision (Leroux et al, 2022).

Figure 14: Map and number of referrals by organisation and Suffolk District, 2022–2024 aggregate totals.



District	Brave Futures	ISVAs	Restitute	SiT
Babergh	-	179	23	247
East Suffolk	85	379	168	678
Ipswich	263	477	85	667
Mid Suffolk	-	131	19	94
South Norfolk	-	10	5	-
West Suffolk	124	411	65	521

Demographic data

A full breakdown of the demographic data received, including categorisation and classification discrepancies between services, and areas of missing data, are presented in **Appendix B**.

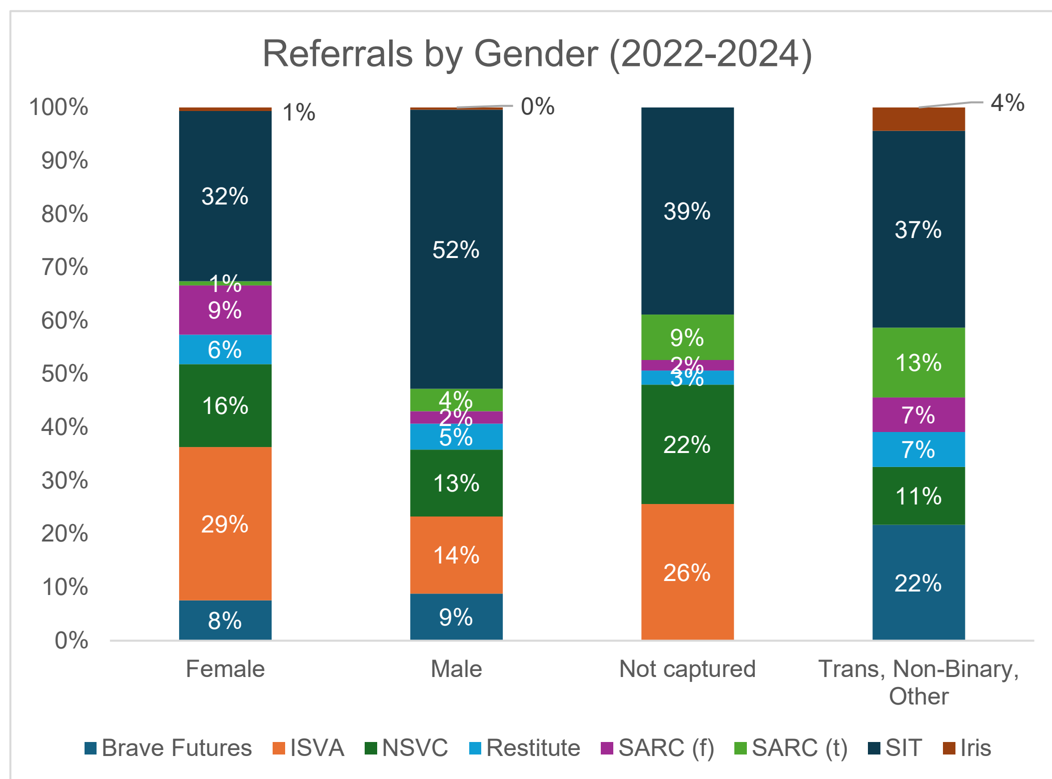
Gender 2022–2024

Gender was captured by all organisations, however there were differences in how the data was recorded: one service captured categories for genderfluid and transgender male specifically, while another had a category for nonbinary and recorded androgynous as a separate category in 2023, but none for transgender. These inconsistent and small categories suggest 'ad-hoc' recording of gender-diverse individuals.

Referrals to all organisations were overwhelmingly female. Brave Futures and ISVA provide support to around two thirds of all female victim survivors (61% of all female cases), whereas support for male victim survivors is disproportionately provided by SiT (52% of all female cases), as well as over a third of support provided for trans, non-binary or 'other' victim survivors (37% of all female cases), followed by Brave Futures (22% of all trans, non-binary or 'other' cases), see Figure 15. This weighting towards women and girls being referred into organisations is likely reflective of the gendered nature of sexual violence, however it could also be due to men and gender diverse individuals feeling that some services are not for them. This interpretation is supported by the interview data, for example one interviewee said:

> *'I think within that [one front door] there would be more services specifically designed at men, for example within the SARC, men are given a choice of examiner, whether they want to see a male or a female, and within support services, I know that is also reflected. They are given a choice. But some men would prefer to go to men only groups, for example, and there isn't that provision currently.'*
>
> **(Interview, Practitioner, 2)**

Figure 15. Referrals by gender, shown as individual proportions of service providers for the total number of cases per gender category e.g., SiT provides support services to 32% of all female cases captured in the present dataset.



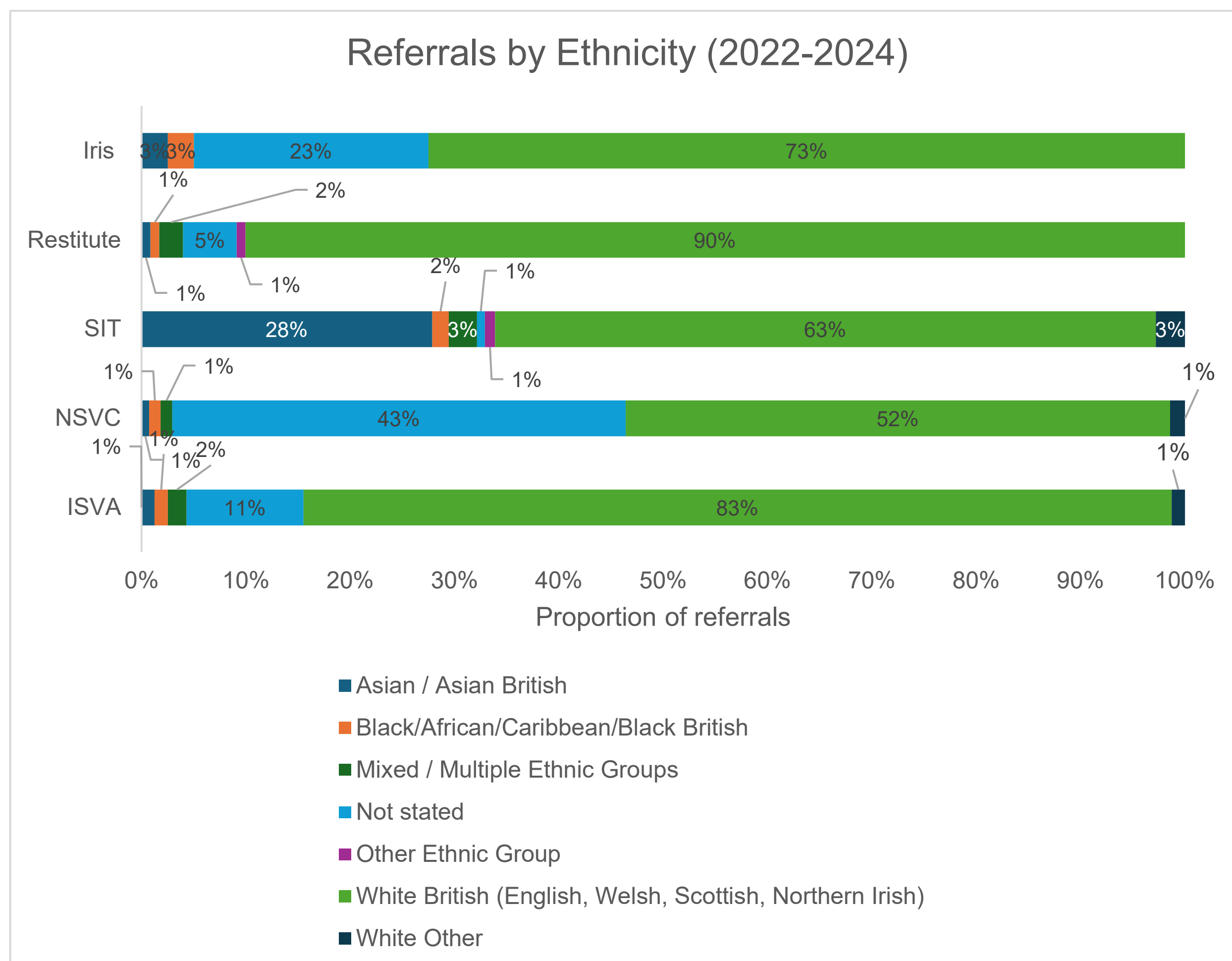
Referrals by Gender	Brave Futures	ISVA	NSVC	Restitute	SARC (f)	SARC (t)	SiT	Iris
Female	8%	29%	16%	6%	9%	1%	32%	1%
Male	9%	14%	13%	5%	2%	4%	52%	0%
Not captured	0%	26%	22%	3%	2%	9%	39%	0%
Trans or Non-Binary	22%	0%	11%	7%	7%	13%	37%	4%

Ethnicity 2022–2024

Ethnicity was also recorded in an inconsistent way. Two organisations did not provide ethnicity data. Two organisations went by a higher-level ONS recording method, while three went by a more granular ONS recording method with some inconsistencies between them. However, even merging categories into a smaller number, data were still insufficient to form any detailed conclusions about support provided to victim survivors of different ethnic backgrounds: while all service providers predominantly support White British individuals, a lot of data for this demographic was not available. However, incomplete data does suggest that SiT is more likely to provide support services to victim survivors from an Asian (or Asian British) ethnic background. See Figure 16.

In line with the demographics of Suffolk (93% White, 2.3% Asian, 2.3% Mixed, 1.3% Black, and 0.9% Other — Suffolk Observatory, 2021), the highest percentage of referrals were White British: 90% of Restitute's referrals and 83% of ISVA referrals. Norfolk and Suffolk Victim care had a slightly lower rate of White British referrals (52%), however their next highest category was "not stated", which suggests some data was not captured. A percentage within each organisation was also categorised as "not stated", indicating some demographic data is being lost. Asian or Asian British and Black/African/Caribbean British each had low portions of referrals, 1–2% in each organisation. This may reflect the demographic makeup of Suffolk as a whole, however there may be other factors such as minoritised victim/survivors not having their needs met fully by services, struggling to know where to go, or reluctance to report or disclose in the first place.

Figure 16. Referrals by ethnicity, shown as the proportion of ethnic background categories recorded per service.



Referrals by Ethnicity	ISVA	NSVC	SIT	Restitute	Iris
Asian / Asian British	1%	1%	28%	1%	3%
Black/African/Caribbean/Black British	1%	1%	2%	1%	3%
Mixed / Multiple Ethnic Groups	2%	1%	3%	2%	0%
Not stated	11%	43%	1%	5%	23%
Other Ethnic Group	0%	0%	1%	1%	0%
White British (English, Welsh, Scottish, Northern Irish)	83%	52%	63%	90%	73%
White Other	1%	4%	1%	3%	0%

Age 2022–2024

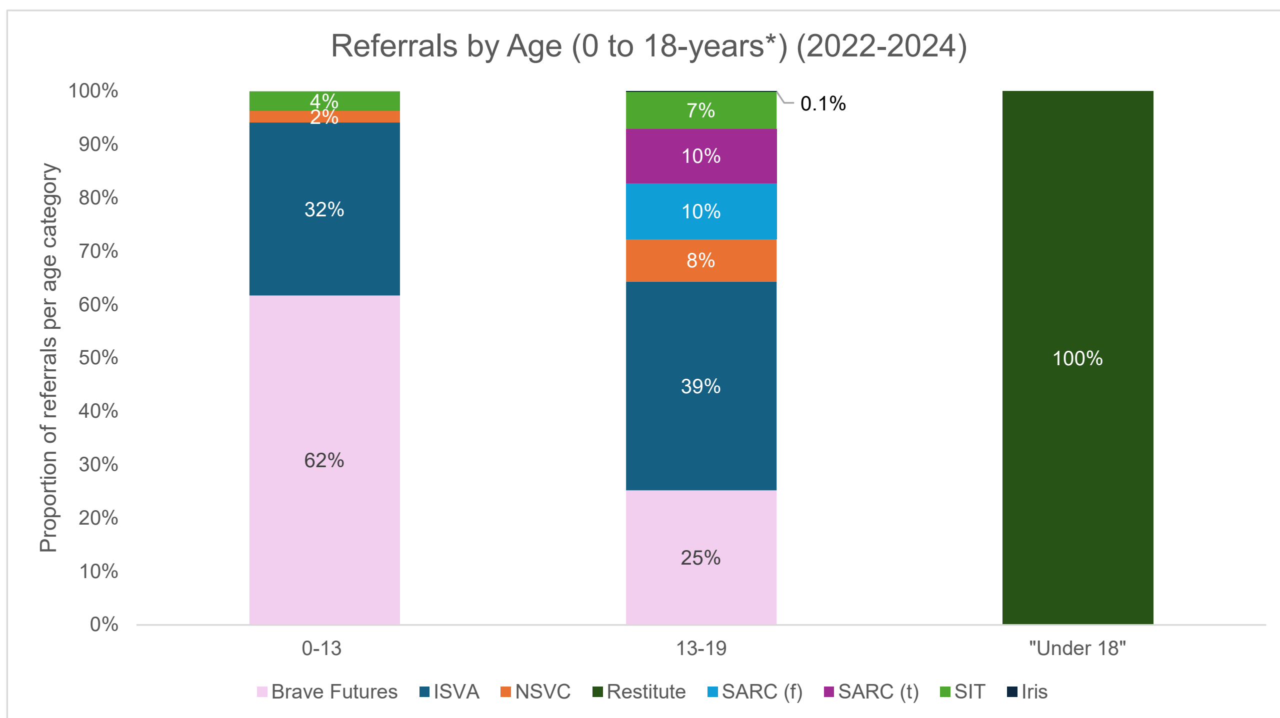
All organisations provided age information, but there were substantial differences in how this was captured. To illustrate, two organisations provided referral data for each single age year 0–17 and 13–97 respectively. One organisation provided age group data for up to 18, then 18+, as they are a CYP service, while two other organisations also provided age group data with similar groupings from 18–24 onwards but large inconsistencies before this (i.e., one of the two had 12 and under, 13–17, and 17 and under as age groups). These inconsistencies in age groupings are the case across all age data, making it difficult to draw comparisons between services. For the present report, age categories were merged where possible, and 'split' equally in some cases where possible. The following is a close approximation of support provided to victim survivors of different age brackets.

For victim-survivors 18-years and under, Figure 17 shows that for those 0 to 13-years, most service support is provided by Brave Futures (62%), followed by ISVA (32%). For those aged between 13 and 19-years, ISVA serves the most individuals (39%), followed by Brave Futures (25%). Both Brave Futures and ISVA appear to be the leading support service providers for victim-survivors aged 13-years or younger, where access to support from other services e.g., SARC, NSVC increase with victim survivors' age e.g., from 13- to 19-years, and into adulthood. For adult victim survivors aged 19-years and over, Figure 18 shows that NSVC and SiT are the two leading support providers for victim survivors aged 18- to 24-years (36% and 27%, respectively).

For victim survivors aged 25- to 30-years, SiT is the leading support provider, followed by ISVA (47% and 22%, respectively). For victim survivors aged 31- to 40-years, SiT and NSVC and ISVA are the three primary support providers (36%, 23% and 22%, respectively). For victim survivors aged 41- and 50-years, SiT is the primary support provider, followed by NSVC (40% and 22%, respectively). For victim survivors aged 51- and 6-years, SiT is the leading support provider, followed by NSVC (54% and 18%, respectively). For victim survivors aged between 61- and 70-years, service support is largely shared by both SiT and NSVC (34% and 28%, respectively).

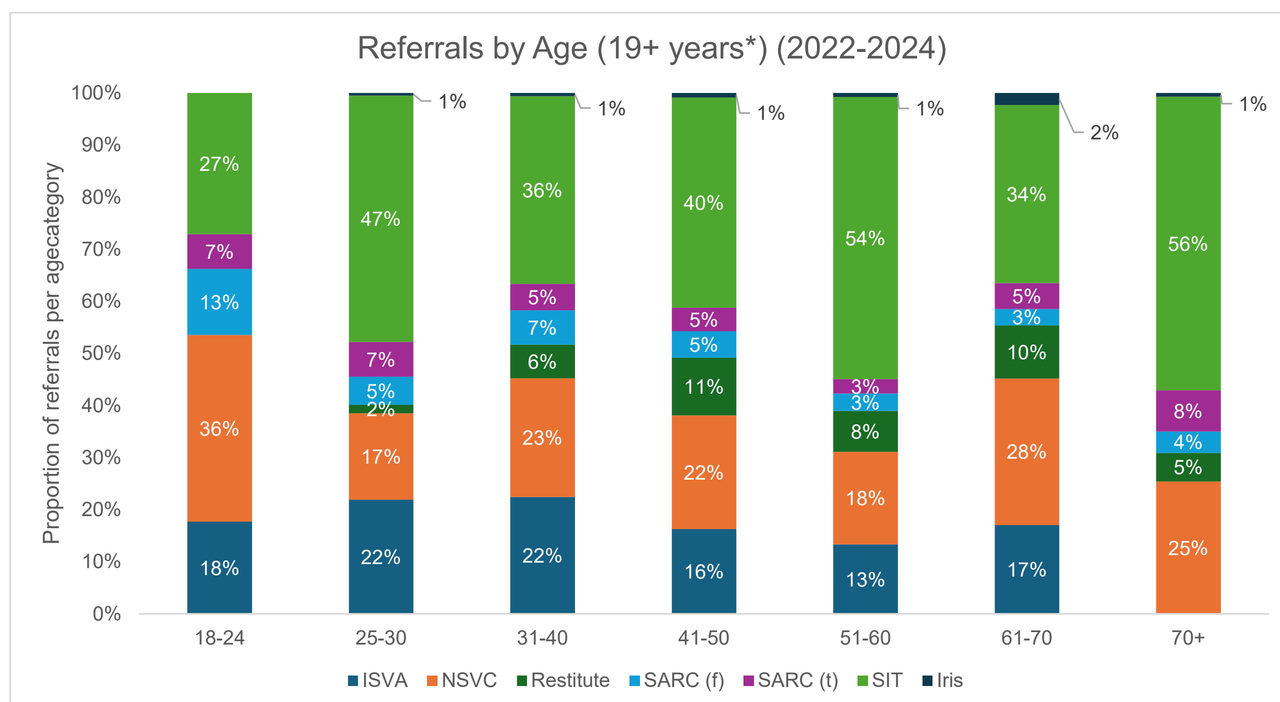
Finally, for victim survivors aged 70 and above, SiT is the primary support service provider, followed by NSVC (56% and 25%, respectively). Overall, these figures show that although the source of service provision appears to differ according to the age of the victim survivor, Brave Futures and ISVA provide support to the majority of young victim survivors (<18-years). Once into adulthood, SiT accounts for most service provision, followed by NSVC and then ISVA. This trend is consistent across all age categories.

Figure 17. Referrals by age category for child victim survivors, shown as the total number of victim survivors per age bracket, where percentages refer to the proportion of support services associated with a given age category e.g., Brave Futures account for 62% of the support services provided for 0- to 13-year old victim survivors.



Referrals by age	Brave Futures	ISVA	NSVC	Restitute	SARC (f)	SARC (t)	SiT	Iris
0–13	62%	32%	2%	0%	0%	0%	4%	0%
13–19	25%	39%	8%	0%	10%	10%	7%	0.1%

Figure 18. Referrals by age category for adult victim survivors, shown as the total number of victim survivors per age bracket, where percentages refer to the proportion of support services associated with a given age category e.g., NSVC account for 36% of support services provided for 18- to 24-year old victim survivors.



Referrals by age 19+ years	ISVA	NSVC	Restitute	SARC (f)	SARC (t)	SIT	Iris
18–24	18%	36%	0%	13%	7%	27%	0%
25–30	22%	17%	2%	5%	7%	47%	1%
31–40	22%	23%	6%	7%	5%	36%	1%
41–50	16%	22%	11%	5%	5%	40%	1%
51–60	13%	18%	8%	3%	3%	54%	1%
61–70	17%	28%	10%	3%	5%	34%	2%
70+		25%	5%	4%	8%	56%	1%

Disability

Many organisations did not record disability, and those who did record it did not define it, except for the SARC service, who recorded 'learning disability only'. Like age, this makes comparison very difficult, however some binary yes/no information is present. Victim-survivors were more likely to be disabled than not when asked, with Restitute showing the lowest number of referrals who stated a disability (90% 'no'). SiT had the highest number of disabled victim/survivors (23% 'yes').

Recommendation 7 of this report is to gain greater insight into the specific needs of certain groups not represented in the existing data, such as victims who identify as male and those from minoritised groups, including by ethnicity and gender. This recommendation is echoed in Ward and Puleston's (2025) report into the experiences of victim-survivors in Suffolk.

Recommendation 7 of this report also calls for a more robust approach to accurate and standardised collection and recording of victim-survivor data, by both statutory and service providers. Clearer data collection would enable an understanding of the demand for services and create an accurate evidence base of the need for future funding. We have developed a template to standardise data collection by all service providers, see **Appendix C**, to suggest to commissioners the benefits of a system which records clear and replicable data.

The findings from the aggregated data from service providers show a steady year-on-year increase in referrals, with Ipswich and West Suffolk geographically having the highest number of referrals. Demand outweighs the level of support which can be provided on current funding levels.

Relevant statutory services include Suffolk Constabulary and The Ferns Sexual Assault Referral Centre (SARC). Based on survey feedback, the ISVA service is valued by victim-survivors alongside local provision.

The wider evidence base also indicates that adult victim-survivors of childhood sexual abuse often seek support during adulthood in healthcare settings, with around one in four surveyed first disclosing to a mental health professional (Gekoski et al, 2020). Specialist sexual violence voluntary sector and community-based services include SiT, Restitute, Iris and Brave Futures. Other providers in Suffolk who offer support for victim-survivors but who are not sexual-violence specific includes PHOEBE, who provide a range of culturally responsive, community-based support programmes for Black women and girls. These services were explicitly named by victim-survivors as providers of much-needed support.

Access to support is a commonly reported barrier nationally, where survivors of sexual violence are often unaware of the support available or how to locate it, which may inhibit survivor disclosure and/or support seeking (Chowdhury et al., 2022; Frost, 2019; Huntley et al., 2020; Javaid, 2020; Widanaralalage et al., 2024). This finding from the national evidence base was reflected at the local level, with victim-survivor feedback collated through the call for evidence survey suggesting that some participants felt under-informed about how and where to access support (further explored in the discussion of language and communication issues identified by survey participants). Among victim-survivors who completed the survey, the majority were women (91.9%, n = 34), aged between 35–44 years (35.1%, n = 13), and came from a White British ethnic background (81.1%, n = 30). The majority identified as heterosexual (73%, n = 27) or bisexual or pansexual (18.9%, n = 7). No participants identified as transgender. Around one in six participants considered themselves to be disabled (16.2%, n = 6).

Findings from the surveys and interviews indicate that victim-survivors in Suffolk have access to a range of voluntary and statutory sector services, including services open to children, young people and adults, men, women and non-binary individuals, and third-party victims. There are self/referral pathways available for victim-survivors who wish to report their experiences to police and be supported through this process, as well as for most victim-survivors who choose not to, or do not feel able to, engage with the criminal justice system. There are DA focused organisations, for example, Lighthouse Women's Aid, Bury St Edmunds Women's Aid and Compassion, for those who have experienced sexual violence in the context of DA, who seek support via non-statutory provision.

> *'In terms of where I think there are gaps is you know there's no golden thread between our data. 70% of survivors who access [our service] have never reported their abuse. So, if we look at the police data, I'm looking at that going "Well, I can increase that by an extra 70%".'*
>
> **(Interview, Practitioner, 2)**

Geographical gaps in provision across the UK that require individuals to travel long distance (Chowdhury & Winder, 2022; Javaid, 2020; Lowe, 2018; Madoc-Jones, Hughes & Humphries, 2015; Olabanji, 2022), and often inconsistent criteria for onward referral, may also restrict access to support. For example, eligibility to receive support from mental and social health care sectors is often based on strict criteria, and similarly onward referrals to other services by the police depends on whether individual cases are considered high impact or not and affect who can and cannot seek and receive support (Chowdhury & Winder, 2022; Madoc-Jones, Hughes & Humphries, 2015; Widanaralalage et al., 2024). Our data suggests these findings are replicated in Suffolk:

> *'Due to the number of people needing to access services — the services currently in place do well not to overlap with what they are providing. There are some very experienced practitioners in many roles who are committed to providing quality support and therapy to victims of sexual violence.'*
>
> **(Survey, Practitioner, 11)**

Funding

Funding was the main recurring issue for professional participants, with several survey and interviewee participants' perceptions that the closure of Suffolk Rape Crisis in July 2024 was due to insecure funding and highlighting this as indicative of wider issues at the local and national level. However, there were differing perceptions of what caused the closure of this service, with a commissioner interviewee attributing its closure not to withdrawn funding, but to internal governance:

> *'I just do want to just mention [Suffolk] Rape Crisis. So what happened there — we would never ever withdraw funding from anything, contrary to what [local newspaper] reported in May of last year, that's complete rubbish. What happened was they've had all sorts of staffing problems and so on, and the money they hadn't spent, that was supplied from us to them. We kept the rest of that and handed it over to [another local SV specialist service] and that team, and they're taking up some of the slack. Longer term, of course we need a permanent solution.'*
>
> **(Interview, Commissioner, 1)**

Recommendation 1 in this report is the need for greater security of income, both locally and nationally. Among professional survey participants, funding was most cited as a gap or barrier to effective provision at the local level (n = 13), and several victim-survivor participants (n = 5) expressed similar concerns, linking insufficient funding for in-demand services to experiencing long delays in accessing support:

> *'I have been fortunate enough to have done DA courses with Compassion and found them friendly and knowledgeable and supportive. However, I know they are stretched and I had to wait a while to be booked onto a course which at the time actually didn't help because when I needed it reaching out first was when I probably could have done with them.'*
>
> **(Survey, Victim-Survivor, 13)**

While services are in principle open to victim-survivors across the county, interview and survey findings suggest that, in practice, there is a perception that services are concentrated in more urban areas such as Ipswich, with disparities in accessibility for those living in rural areas.

> *'There is a shortage of services in more rural areas.'*
>
> **(Survey, Victim-Survivor, 5)**

> *'It can be challenging for clients who live in the more rural parts of the county to access services.'*
>
> **(Survey, Practitioner, 11)**

While advocacy-based services such as ISVAs or Iris (a community sexual assault service for people who have experienced sexual violence) can travel to victim-survivors, location can pose more of an issue for those seeking specialist counselling or therapy.

> *'Sometimes therapy, if they want face to face, is quite often only accessed in Ipswich [...] If you're coming from Lowestoft or surrounding areas, you're talking an hour plus journey time.'*
>
> **(Interview, Practitioner, 7)**

Commonly identified barriers to victim-survivors finding and accessing support included lengthy waiting lists (n = 9), delays in the criminal justice process (n = 6), and language and communication issues (n = 11). Issues also included sparse, unclear and/or non-trauma-informed messaging from police and other services.

> *'After SV you are immediately thrown into the police system — people talking acronyms, terms you don't understand.'*
>
> **(Survey, Victim-Survivor, 28)**

> *'Police can be uneducated and rude.'*
>
> **(Survey, Victim-Survivor, 17)**

> *'I believe that the police could work better with the victims and maybe be more trained to show empathy and understanding of the victim.'*
>
> **(Survey, Victim-Survivor, 12)**

Professionals and commissioners particularly highlighted challenges linked to funding and commissioning, including a hesitancy to publicise over-stretched services and therefore risk

further adding to waiting lists, and concerns about new services being commissioned without due consideration for how these complement existing services and the potential for duplication.

> *'I'm caught between a rock and a hard place at the moment, because I could go out and tell the world about what we do and how fantastic it is, but I've already got a waiting list of 50 families. So, what I would like to say is give me enough money to be able to effectively run this support service for everyone who needs it, and I will go and bang on about it.'*
>
> **(Interview, Practitioner, 3)**

The issues with both waiting lists and the subsequent delays were highlighted in the recent report by Ward and Puleston (2025) about Suffolk. Delays when navigating criminal justice processes, and the emotional toll that such delays can bring for those affected by sexual violence, was also identified as a major issue within the Suffolk system. Participants reported encountering significant delays in receiving support, with resource-related factors playing the most prominent role in contributing to this picture.

> *'Personally I had to wait [to receive services], this then left me still with my perpetrator.'*
>
> **(Survey, Victim-Survivor, 13)**

> *[When invited to reflect on what could work better locally] 'Less than three months for engagement to start.'*
>
> **(Survey, Victim-Survivor, 18)**

> *'From first arrest to imprisonment of the perpetrator, getting counselling was for the victim was impossible, being told you cannot talk about what's happened, when the whole process was four years.'*
>
> **(Survey, Victim-Survivor, 23)**

> *'ISVAs are helpful but to get emotional support is very difficult. NHS wait lists are long, private therapy there is also a wait and there's no-one to explain what you actually need. There are a number of charities that try to fill gaps but all also have waiting lists, allow limited sessions and have different criteria so it's difficult to find them [...] I found it exhausting trying to find the help needed.'*
>
> **(Survey, Victim-Survivor, 28)**

Other participants identified more pervasive issues with communication at the local level. One participant felt that there was a lack of timely, digestible guidance for victim-survivors on where to access support after reporting, leaving some people adrift following their initial report.

> *'I think that when you report about sexual violence that there should be someone who can be appointed to you straight away and give you as much info as possible about organisations that can help. Sometimes a victim is left for weeks before giving this information.'*
>
> **(Survey, Victim-Survivor, 24)**

Others felt that there was limited public messaging about the services available, leaving victim-survivors in the dark:

> *'I feel there is a real lack of awareness on what services are available and also services available to those who need it.'*
>
> **(Survey, Victim-Survivor, 13)**

Notably, the Code of Practice for Victims of Crime in England and Wales stipulates that victims who report to police have the right to be referred to support services within two working days (Ministry of Justice, 2025). The Victims and Prisoners Act 2024 requires police and other criminal justice bodies to collect data on their compliance with the Code, to drive and inform service improvements. Suffolk PCC data for the period of 1 January 2024 to 31 December 2024 illustrates that 97.5% of 'vulnerable victims' (including those affected by sexual violence) were referred to victim support within the statutory guidance period (Suffolk PCC, 2025). This encouraging local finding should be considered before drawing inferences about wider trends based on the specific experiences of individual victim-survivors, as should the low number of survey participants overall and the qualitative (experiential and depth-focused) nature of the data.

Additionally, it is also important to note that national and local data indicates that only a minority of victim-survivors choose to, or feel able to, engage with the criminal justice system regarding their experiences of sexual violence (HMICFRS, 2021). Therefore, increasing awareness about the local services available to all victim-survivors (whether or not they choose to report), is likely to benefit a broader range of people affected by sexual violence, reducing the opportunity for any victim-survivor to fall through the cracks owing to a lack of knowledge of available support.

RQ2: What do sexual violence survivors, practitioners and commissioners across Suffolk understand the strengths and limitations of sexual violence service provision to be?

> *'I think we've got some really great services in Suffolk. You know, Brave Futures and SiT [...] I think there's, you know there's some really passionate people within those organisations that really want to make changes and really want to support those that have experienced sexual abuse.'*
>
> **(Interview, Practitioner, 5)**

> *'Funding! Not enough money to provide enough support workers to meet current demand. I manage a waiting list of over 30 people with waiting times exceeding five months.'*
>
> **(Survey, Practitioner, 23)**

> *'The people are amazing, the system lets them down.'*
>
> **(Survey, Victim-Survivor, 23)**

> *'ISVA provided to support my family with the legal/criminal prosecution side of things. Restitute for helping myself and my wife come to terms with what has happened and dealing with emotions, feelings, uncertainty and a friendly supportive person at the end of a phone.'*
>
> **(Survey, Victim-Survivor, 32)**

In relation to what is working well, participants in the call for evidence survey for victim-survivors described receiving high-quality support and guidance from specific professionals and services, including voluntary sector organisations such as Survivors in Transition (n = 6), Restitute (n = 5), Compassion (n = 1) and Lighthouse Women's Aid (n = 1), and statutory sexual violence services such as ISVAs (n = 8), police (n = 2) and the Ferns SARC (n = 1).

Accessing support from specialist services was seen to promote understanding and aid victim-survivors in navigating wider systems such as criminal justice processes, as well as in comprehending what has happened to them:

> *'Working with my ISVA has been so helpful to learning to understand the process of reporting offences and helping with referrals for therapy. I work with Survivors in Transition as well and these weekly sessions help me understand what's happened to me.'*
>
> **(Survey, Victim-Survivor, 12)**

This quote also points to the level of reciprocal collaboration between services, particularly for those who choose/feel able to report to police, with voluntary sector services delivering emotional support and assisting those affected by sexual violence to make sense of their experiences, while statutory sector services facilitate people's journeys through the criminal justice system.

A minority of participants (n=2) felt that there were few areas of Suffolk sexual violence provision that were working well, such as specialist support in the voluntary sector (when available) and the variety and quality of services available. The maintenance of specialist support was advocated by Ward and Puleston (2025). However, others cited the challenges associated with finding support, and the time-limited nature of available services. Collaborative relationships between established sexual violence specialist services were also identified as a highlight of local provision by several interviewees.

In addition to lengthy waiting lists to access services, some participants had a more complex interaction of factors, including systemic and cultural barriers, such as the persisting stigma associated with sexual violence victimisation and concerns about being judged or disbelieved should they choose to disclose. These factors were perceived to be linked to delays in disclosure and seeking support by both victim-survivors and professionals.

> *'Feeling safe to tell someone.'*
>
> **(Survey, Victim-Survivor, 6)**

> *'Rape is the easiest crime to get away with as it's nigh on impossible to prove you didn't consent. Even if you get past CPS, the thought of going to court is deeply unpleasant.'*
>
> **(Survey, Victim-Survivor, 28)**

> *'The importance of belief of the victim. Fortunately, I have been well supported by all services in this area, however I know this is not always the case.'*
>
> **(Survey, Victim-Survivor, 37)**

> *'Stigma and shame about what happened [...] Misconceptions about who is affected — can happen to anyone. Racism and homophobia and poverty can also be barriers for the survivors. Being known to the whole community.'*
>
> **(Survey, Practitioner, 12)**

In addition to concerns about delays, participants also cited deeper dysfunctionalities in how the criminal justice system deals with sexual violence, and the significant impact this has on victim-survivors and society more broadly, with knock-on effects for trust and confidence in policing.

> *'I do feel let down by the police as despite my reporting not only the abuse at the start, but the continued abuse and harassment following separation they missed and reported things wrongly and then let him get away with more and have since done a NFA [No further action] after over a year. The police need to do more and charge more perpetrators so it gives victims and survivors more hope for justice.'*
>
> **(Survey, Victim-Survivor, 13)**

Another participant noted that reporting to the criminal justice system can result in feeling, or being, disbelieved, compounding the trauma of having experienced sexual violence. This participant called for greater support for:

> *'Victims of rape where police has resulted in NFA and the ongoing trauma of not being believed or being told it was a "false allegation".'*
>
> **(Survey, Victim-Survivor, 16)**

As with perceptions about what was currently working well, there was substantial alignment between victim-survivor and professional perspectives on gaps and barriers in Suffolk sexual violence services, particularly in relation to delays in accessing support and delays with criminal justice processes.

> *'The length of time from reporting to the police to CPS and then court, takes far too long and is agonising for the victims, their families.'*
>
> **(Survey, Practitioner, 33)**

> *'Extremely long waits for court proceedings, waiting times for mental health services and counselling.'*
>
> **(Survey, Practitioner, 3)**

In relation to gaps and dysfunctionalities in local provision for services and those affected by sexual violence, commonly identified issues included lack of funding, delays in accessing support and criminal justice processes, and language and communication barriers puts additional demand on support services. The recent closure of Suffolk Rape Crisis also featured prominently in some responses, with discussion of the impact on local victim-survivors and ripple effects for remaining services. This was also recently highlighted by Ward and Puleston (2025).

When asked about what works well in Suffolk sexual violence provision, professional respondents cited the quality and variety of services available locally, including the ISVA service, SiT, The Ferns, Brave Futures and Iris. Rather than highlighting areas of duplication or overlap, for the most part, participants characterised specialist sexual violence services as working in a collaborative and complementary manner.

When invited to reflect on areas they felt could be improved within local provision, professionals and commissioners focused on some common issues, also highlighted by survey participants, including a need for sufficient, sustainable funding. Additionally, short-term funding contributes to the systemic

barriers to finding and accessing support identified by victim-survivors, including lengthy waiting lists and limited advertising of available services. When visualising what 'sufficient funding' might look like based on the evidence of survey participants and interviewees, we note that this appears to be a functional or pragmatic definition based on timely access to support for victim-survivors, who may initially disclose or seek support during a time of crisis, and an increased sense of stability for professionals, whose job security is tied to time-limited funding.

RQ3: What are the potential benefits of effective sexual violence service provision? How can different models of service provision deliver integrated/place-based systems of support for survivors with varying needs?

> *'A holistic triage of all referrals into one specific portal. A needs assessed review of each referral would ensure each client can access the service they need, at the time they need it, rather than waiting for something that may not even be appropriate.'*
>
> **(Survey, Practitioner, 32)**

> *'I think what's working well at the minute is the choices that people have in terms of whether that's as a self-referral or as a police referral, from the minute they disclose that choice is given to them from the offset and the options explained to them on how best it is that they feel they want to report.'*
>
> **(Interview, Practitioner, 8)**

> *'Medical and specialist mental health services under one roof and somewhere where you don't have to continually disclose.'*
>
> **(Survey, Victim-Survivor, 21)**

> *'Access to long-term support at multiple stages of investigating as emotions change through the journey.'*
>
> **(Survey, Victim-Survivor, 9)**

Participants suggested an effective place-based system would include increased awareness of different stages of victim-survivors' journeys and the recognition that people's need for support will vary over time and that many victim-survivors may never wish, or feel ready to, report to police (Wenham and Jobling, 2023). Better integration of services is essential. Multidisciplinary collaboration, improved data recording and sharing of consultations, and coordinated transitions between services can prevent re-traumatisation and ensure seamless support (Olabanji, 2022).

Greater joined-up working is further advocated in the report by Ward and Puleston (2025) and our **Recommendation 6** highlights the need for a trauma-informed approach to supporting victim-survivors, with commissioners committing to supporting a whole system approach. Hermolle (2023) highlighted findings from a trauma-informed practice benchmarking exercise that illustrated a need for a joined-up approach across the system, and that approaches to victim/survivors need to be totally service user and needs-centred, which must begin with policy and commissioning strategy.

Despite recent efforts, more innovation and evaluation in-service models are needed to meet survivors' diverse needs, with evidence-based approaches and improved commissioning practices

offering a path forward. Personalised support reduces barriers such as language, cultural differences, and gender discrimination, while fostering continuous, holistic care (Damery et al., 2024). Increased funding and national prioritisation are essential to reduce staff turnover, retain skilled professionals, and deliver consistent, high-quality support without the constant pressure to secure financial resources (Madoc-Jones, Hughes & Humphries, 2015).

Recommendation 3 of this report is that demand should be co-ordinated through both diverse and existing services. Participants described receiving high-quality support and guidance from specific professionals and services, including voluntary sector organisations such as SiT (n = 6), Restitute (n = 5), Compassion (n = 1) and Lighthouse Women's Aid (n = 1), and statutory sexual violence services such as ISVAs (n = 8), police (n = 2) and the Ferns SARC (n = 1).

The loss of Suffolk Rape Crisis in July 2024 has left a gap in gender-specific specialist provision for women affected by sexual violence, although services including SiT and Iris provide specialist gender-inclusive support and advocacy. Ward and Puleston (2025) highlight the lack of advertising of specific services, such as women-only spaces. As one of our interviewees said:

> *'The closure of our Rape Crisis Centre has had a huge impact in reducing the services available to female adult survivors of sexual violence, especially in regards to long-term therapeutic support and accessing a female-only space.'*
>
> **(Survey, Practitioner, 2)**

Several participants expressed that existing sexual violence organisations were already providing high-quality support, but that their capacity to meet the level of demand was limited due to funding issues. Professional survey participants expressed similar views to those affected by sexual violence, with responses commonly referencing timely, trauma-informed and needs-led support, increased funding, reduced criminal justice system delays and a hub or 'one front door' approach.

When envisioning what an ideal service system might look like, respondents described a holistic and victim-centred model, facilitated by sufficient and sustainable funding and smooth multi-agency working.

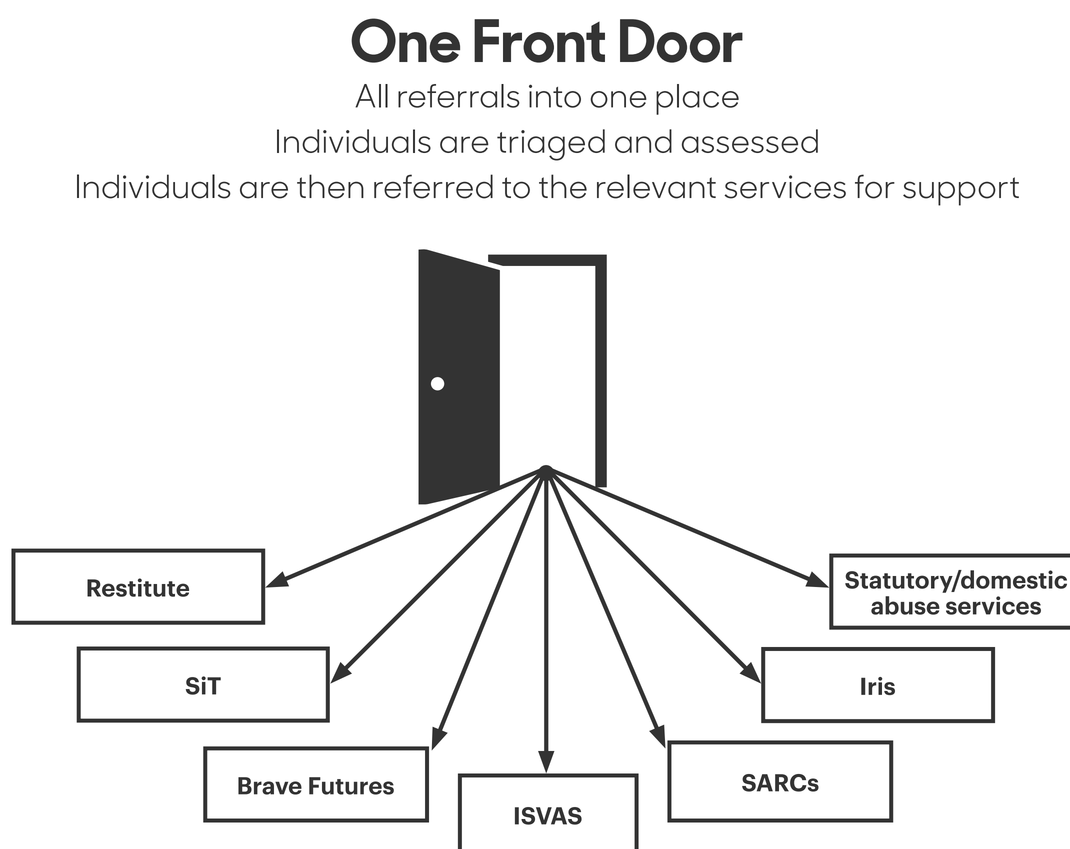
> *'A hub approach — with all the services working together to provide therapies and intervention/ support, no waiting lists/sustainable funding for long-term.'*
>
> **(Survey, Practitioner, 11)**

Visions of what a place-based system might look like included introducing a streamlined 'one front door' approach, which has worked well elsewhere, for example with Safe Lives (**www.safelives.org.uk**) with the aim of reducing waiting times and inappropriate referrals and preventing victim-survivors seeking support from having to re-tell their stories unnecessarily. This model has recently been adopted by Synergy Essex (2025) a specialist, community-based provider, who offer a first contact service to advocacy, support and signposting services in Essex. In keeping with this vision, several professionals identified a need for a more collaborative and integrated approach at the systems-level, with local commissioners and services working together to close gaps, address areas of unmet need, and prevent duplication.

A service which meets the needs of specific demographic groups is supported by the victim-survivor report in Suffolk (Ward & Puleston, 2025). Such an approach would not entail moving to a generic or 'one size fits all' model of provision whereby one organisation or consortium is commissioned for all services, nor would it prevent victim-survivors who wish to self-refer directly to a specific service from doing so. It would provide a central, clearly signposted and accessible referral route into one or more of the existing services available locally, based on each victim-survivors' specific preferences and profile of needs.

The suggestion of a 'one front door' approach (Figure 19), for victim-survivors to receive guidance at the point of triage, whilst still retaining direct access to existing services if preferred, is **Recommendation 4** of this report.

Figure 19: Visualisation of the 'one front door' approach.



The perception that sexual violence remains to some extent a "poor relation" within the VAWG family when compared to domestic abuse was voiced by several professional participants. This disparity was seen to contribute to reduced visibility of sexual violence services locally and, in some instances, to result in inappropriate referrals by professionals, adding to the administrative burden for sexual violence services and potentially increasing delays for victim-survivors in receiving tailored support. Other recurrent findings among interviewees regarding gaps and barriers at the local level included a disparity in awareness between domestic abuse and sexual violence, and the need for increased investment in early intervention and prevention efforts. The need for greater prevention-led work is **Recommendation 5** of this report.

A need for additional investment in prevention and early intervention is further supported by Ward and Puleston (2025) in their victim-survivor consultation report. When calling for increased investment in prevention work, we include primary prevention (stopping sexual violence before it starts, through interventions addressing its root causes), secondary prevention (timely response to sexual violence to prevent recurrence or escalation) and tertiary prevention (working to reduce the longer-term harms of sexual violence and preventing reoffending) (The Mayor's Office of Policing and Crime (MOPAC) and London's Violence Reduction Unit, 2024).

Another interviewee agreed with the perception that sexual violence tends to be swept under the VAWG 'umbrella' at times. They also expressed that sexual violence's lower profile may result in a lack of clarity for local victim-survivors as well as professionals, particularly among those who have experienced forms of abuse characterised by manipulation and coercion rather than overt acts of physical violence.

These findings resonate with victim-survivor perspectives regarding language and messaging about sexual violence, and the need for clear, accessible and trauma-informed communication that speaks to a diverse range of individuals, evidenced through survey participants' feedback. The findings from our scoping review on the terminology and language used in sexual violence literature indicates the need for clear and appropriate language and is **Recommendation 2** of this report.

Several interviewees (n = 3) additionally advocated for increased attention and resources to be directed towards primary prevention and early intervention work, particularly with children and young people impacted by sexual violence.

Research by the NSPCC (2025) suggests that one in 20 children in the UK have been victims of sexual abuse. Early intervention was perceived both as a direct or intrinsic good — averting harms and affording victim-survivors timely access to information and support and reducing the likelihood of mounting complexity down the line.

> *'Reducing waiting times. I don't think it's acceptable for any child to face delays in accessing critical support [...] It's essential so that we can provide timely care allowing children to begin recovery sooner [...] A stronger focus on early intervention and prevention through education, awareness in schools and communities is part of that framework. I think for improving where we are in the county, I think it's really vital to identify those risks earlier and reduce harm.'*
>
> **(Interview, Practitioner, 6)**

The impact of waiting times developed as a major theme, with participants reporting extensive delays

across criminal justice, support and mental health services. This theme was closely connected to concerns about funding, which left services under-equipped to meet the intense level of demand.

Some participants felt the ISVA service fulfilled a particularly valuable role, working effectively with people affected by sexual violence and police to ease victim-survivors' path through the criminal justice process and in turn support investigating officers.

> *'The ISVA service is one that is working well within Suffolk. Not only do they positively work with victims, it also helps provide support to police when challenging information needs to be shared with the victim during the investigation process.'*
>
> **Survey, Practitioner, 7)**

Some interviewees also cited the relationship between local services and commissioners as an asset, with one participant describing how their service had forged a 'trusted' working relationship with key Suffolk commissioners over time.

> *'Our commissioning relationship with the PCC [Police and Crime Commissioner] has been on a journey and I use it as an example of good practice nationally [...] You know we have an open door and there's a trusted relationship [...It's] taken [...] years to get there.'*
>
> **(Interview, Practitioner, 2)**

Findings from the call for evidence survey and interviews suggest that there is significant appetite locally for an integrated, cohesive support system, with efficient collation and sharing of data and effective multi-agency working between statutory, voluntary and community-based services. **Recommendation 8** of this report is the ongoing collaborative approach to multi-agency working.

While resource-related issues were perceived as a significant barrier to providing effective and timely support, language and communication issues were also widely cited, highlighting the need for clear, unified and consistently trauma-informed messaging about sexual violence across local services (Brown, 2017). Notably, this barrier intersects with wider issues regarding inconsistent use of terminology and language identified during the scoping and document review.

The described benefits of delivering prompt, trauma-informed support included preventing future harms and reducing the need for costly, ongoing and complex interventions. Further investment in early intervention and primary prevention activities was also identified as a systemic approach to responding to sexual violence, and one which could reduce social and economic costs over the long-term associated with unmet needs.

> *'There's far too much 'wait and see'. There is stuff that parents and carers need to know of eight, nine, ten year olds, which will actually set them up for the sex, drugs and rock 'n' roll years. But what seems to happen is that if a family, if a child at that point of contact appears to be safe and well and doing OK, then they completely disappear out the system, and then five years later they come banging up back through the system [..] The correlation between that harm at eight or nine years old and the subsequent what happens when these children become teenagers and young people just seems to be left to chance and those people are put in a situation where they're scrambling about looking for support when their child becomes this really challenging teenager.'*
>
> **(Interview, Practitioner, 3)**

RQ4: How are sexual violence services commissioned in Suffolk and elsewhere in the United Kingdom?

There are five major funders of sexual violence and other peripheral services, and some services are commissioned by more than one funder (i.e., SiT). The current commissioning processes and the strategies that inform them in Suffolk are illustrated below in Figure 20. The system remains fragmented, for example, Suffolk County Council does not commission any specialist sexual violence services, even though the strategy sits within its remit. NHS England used to fund both ISVAs and SARCs, but now only funds SARCs; ISVAs are commissioned separately by the PCC. It is important to highlight there is no specific sexual violence strategy for Suffolk, Figure 20 refers to sexual violence as part of the wider VAWG umbrella.

> *'Strategically I've never understood why Suffolk County Council holds the VAWG strategy [...] Suffolk County Council don't commission any sexual violence services. So therefore, it's very hard to hold service providers to account through a strategy. So, it seems complicated to me. Again, you know something that I think needs a bit of joined-up thinking.'*
>
> **(Interview, Practitioner, 2)**

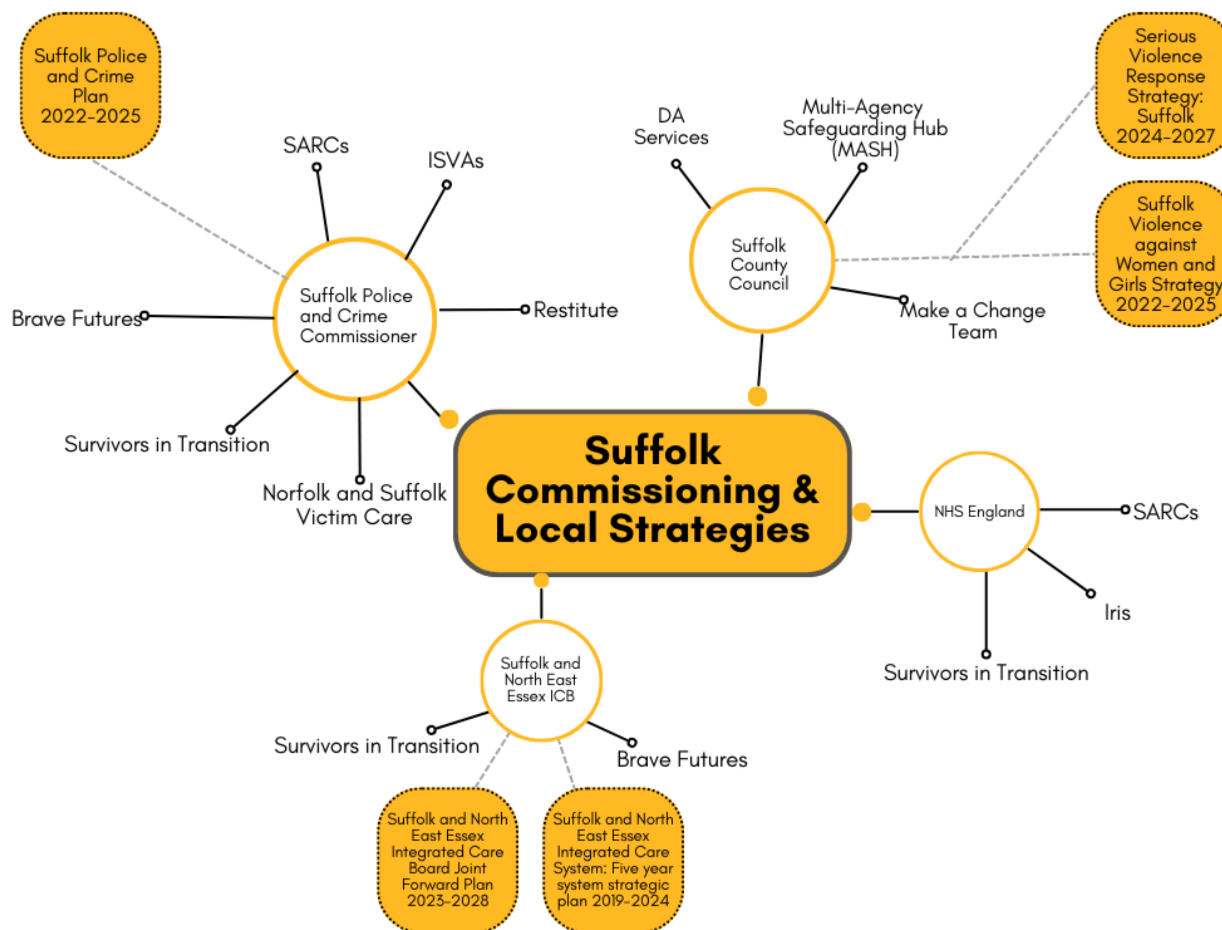
Some interviewees argued that Suffolk should further align aspects of its commissioning with national norms and standards, such as promoting the accessibility of the ISVA service by maintaining a clearer boundary from police.

> *'We're obviously living in a county where we have one of the only police-led ISVA services in the country and I have to mention that in this because I think it's significant and important. [...] Survivors feed that back to us all the time and say that they don't even understand the difference between an ISVA and a police officer. Sometimes they just think they're one and the same thing. They almost think it's like a Victim Liaison role from the police and that is because all of their communications have Suffolk Constabulary on them, their e-mail addresses [...] So they're intrinsically connected to the police, which makes them not independent. So for me there is a need in Suffolk for us to have an independent ISVA service.'*
>
> **(Interview, Practitioner, 2)**

There is, however, evidence of good local practice, with the PCC and funders being responsive to input from service providers.

> *'I think the systems as joined-up as it can be. I think there's always room for improvement, but I think there's good relationships between service providers [...] We have some really strong service providers who are incredibly good at what they do and provide a very good service.'*
>
> **(Interview, Commissioner, 4)**

Figure 20: Visualisation of current Suffolk commissioning and local strategies[1].



N.B.: There is no specific Sexual Violence Strategy for Suffolk. The strategies mentioned refer to sexual violence as part of the wider VAWG umbrella.

It is important to note that while local commissioning is the primary mechanism, some national funding streams and initiatives also support sexual violence services in the UK, such as the Ministry of Justice's Rape Support Fund. There are several problems and challenges associated with sexual violence service provision nationally in the United Kingdom, as funding at a national level is fragmented and uncertain. **Recommendation 8** is a national funding strategy to be prioritised, to create local knowledge and evidence of best practice.

1 There is a high co-occurrence/overlap of DA and SV, and the wider evidence base shows that racially and culturally diverse victim-survivors often prefer to access culturally specific and by and for services when these are available. We have included DA services and PHOEBE (as a GBV service) as relevant for understanding commissioning of SV provision locally

Service integration

Service integration and messaging are also commonly highlighted areas that require significant improvement. Poor communication and transitions between services, including from child to adult services and from police to social services (Forst, 2019; Lowe, 2018; Madoc-Jones, Hughes & Humphries, 2015; Widanaralalage et al., 2024), results in "patchwork" support that means survivors must regularly repeat their stories (Frost, 2019; Madoc-Jones, Hughes & Humphries, 2015). Several survey participants reported similar experiences of having to repeat their story to multiple professionals and/or services, which were framed as intrusive and potentially distressing:

> *[An ideal service would look like] 'Having a single point of contact with the police so you don't have to explain the trauma to multiple officers in depth.'*
>
> **(Survey, Victim-Survivor, 12)**

> *[An ideal service would look like] 'Medical and specialist mental health services under one roof and somewhere where you don't have to continually disclose.'*
>
> **(Survey, Victim-Survivor, 21)**

> *'There are many many different services which I have contact with, sharing the same info again and again. A service which led that would be awesome, one point of contact which links it all.'*
>
> **(Survey, Victim-Survivor, 37)**

As discussed earlier, Suffolk has a diverse geography and the locality of accessibility to support is a factor for victim-survivors. Women and girls living in rural areas experience place-based inequalities in relation to sexual victimisation and accessing support, due to factors such as economic deprivation and lack of professional/educational opportunities (Wenham & Jobling, 2023); limited and/or unreliable public transport (National Rural Crime Network, 2024).

Due to high demand and limited resources, survivors of sexual violence often face long waiting times to access counselling, therapy and other support services. This delay can exacerbate the trauma and hinder the recovery process. Rural and remote areas may have limited or no access to specialised sexual violence services, with survivors having to travel long distances to receive support. This can create additional barriers, particularly for those with limited mobility or financial resources.

Support services that are not effectively integrated disrupt the continuity of support, with survivors reporting a lack of long-term follow-up/support (Javaid, 2020; Madoc-Jones, Hughes & Humphries, 2015; Widanaralalage et al., 2023), and lost "paper trails" where missing documentation meant that healthcare professions had not consistently recorded whether referrals were made and to which services (Damery et al., 2024). The structure of referral pathways also looks very different depending on the nature of the referring service itself, such that survivors' options and pathways to support vary according to the service (and location) at which sexual violence is disclosed.

Some service providers may lack adequate training, resources and expertise to provide trauma-informed care and effectively support survivors of sexual violence. This can undermine the quality and effectiveness of the services offered. Societal stigma and misconceptions surrounding sexual violence can discourage survivors from seeking help, leading to underreporting and underutilisation of available services.

'There needs to be more believability and less judgement on the survivor [...] There should be a known text/phone service so a survivor can talk to someone to stop thinking they were to blame. I knew I wouldn't be believed so I said nothing [...] I have two experiences, one when I was 11 and one when I was 24. Both were inadequate and it wasn't until I was in my late 30s that I got support from a family centre.'

(Survey, Victim-Survivor, 2)

Disjointed commissioning processes also resulted in perceived duplications in local provision, negatively impacting the relationships between newer and more established services and increasing services' sense of financial precarity and competition.

'Honestly, I really don't think we need a new service. There are plenty of good ones out there that could actually do, continue to do a great job if they just had the right backing, funds, and resources.'

(Survey, Victim-Survivor, 3)

RQ5: What might effective commissioning in Suffolk look like?

There were limited funder/commissioner survey completions (n = 5), so the responses received are not necessarily reflective of the views of all local commissioners or funders. However, the survey responses received nonetheless provided some rich and substantive perspectives on what an effective local system of sexual violence funding and commissioning would look like (and whether such an ideal is realisable), with an emphasis on more coordinated and collaborative commissioning of local services, better system-wide monitoring and information sharing to inform funding, service development and delivery. As with victim-survivors and professionals, funder/commissioner survey responses also highlighted the profound interconnections between national and local systems, and the influence of national funding challenges.

'We need better data and a shared understanding locally [...] Long term assurance of funding for victim services from national sources and then replicating this locally. Move towards local commissioners collaborating with each other — being more open about what funding we have for what purposes, what barriers we individually face. Join up of thinking politically within leaders (locally if not nationally).'

(Survey, Commissioner, 1)

'In an ideal world, you'd put all your money into one pot and commission from that pot and involve survivors to shape what that service looks like from the very conception of it. And I think that's probably where things need to be improved is the pooling of resources.'

(Interview, Commissioner, 4)

'It's really unpredictable. Particularly with the change in government at the moment, obviously delays in the budget announcements, the uncertainty has obviously had a significant impact on planning and delivery, leaving us and other organisations somewhat in limbo at the moment [...] What I feel is needed is a strategic multiyear funding commitment. That would provide much greater stability.'

(Interview, Practitioner, 6)

One participant commented on an ideal sexual violence system as one that is needs-led, evidence-informed and collaborative:

> *'Key would be a local system that is responsive to victims' needs (we need to know what they are!) with a range of offerings depending on need and preference. Ideally one plan/pathway where commissioners are clear on their responsibilities and professionals and practitioners are clear on who is being funded to do what. A joined-up offer/clear message with number/place to go but that victims can access through any point (public/VCSE) if they choose to disclose. A system where victims don't have to retell their stories if support from other specialist organisations is required.'*
>
> **(Survey, Commissioner, 1)**

Another participant felt that the notion of an 'ideal' Suffolk system — and there being any straightforward method to deliver this — was problematic, as it assumes that local funders and commissioners have an unrealistic level of autonomy within/from the wider system:

> *'I don't think that there is an ideal because that necessitates an ability to control the system which we cannot...No-one can. The question is how best to collectively respond to the level of need given the limitations we all have so that we can improve the experience of support and care, but there is not a simple fix that will make everything better for victims and survivors.'*
>
> **(Survey, Commissioner, 4)**

This participant instead advocated for a more pragmatic approach, and greater recognition of how local provision is impacted by enduring systemic challenges such as the straitened funding climate and the bottlenecks caused by growing demand for sexual violence and specialist mental health services:

> *'Community mental health/secondary care services are under significant pressure so long waiting lists — CYP and adult. And the reality is that the commissioned MH crisis support service is a four-hour response (that's the NHSE (NHS England) agreed response rate), and there is no 24/7 crisis response in the way that the public wants/expects for mental health crisis support generally, let alone for victims of sexual violence [...]The level of acuity and complexity that sexual violence organisations say they are dealing with is increasing.'*
>
> **(Survey, Commissioner, 4)**

When describing what an ideal sexual violence service would look like, participants commonly described features that would align with trauma-informed principles, including safety, accessibility, transparency and person-centredness. Several explicitly identified a need for more trauma-informed approaches, including pathways into support that are open-ended, needs-led and adaptable to the individual.

> *'A good service would feel safe and be accessible, supportive, honest and consistent, putting the people they support at the centre of everything and adapting as needed when things change.'*
>
> **(Survey, Victim-Survivor, 3)**

Along similar lines, several participants emphasised that there should be access to ongoing and flexible support which is responsive to the changes of victim-survivors' level of need (n = 5).

'Access to long-term support at multiple stages of investigating as emotions change throughout the journey [...] Low level support like creative journaling could be used to support well-being before more intensive support is given. Less judgement is crucial with a person-centred approach.'

(Survey, Victim-Survivor, 9)

'Accessible and ongoing support which can be in terms of group sessions that focus on coming to terms with what happened, peer mentors, support groups. So many survivors struggle on their own even after they have received support.'

(Survey, Victim-Survivor, 16)

In some instances, participants specifically expressed the desire for a 'one-stop' service, which would enable victim-survivors to access multiple professionals under one roof. Help seeking and recovery journeys are often far from straightforward, and victim-survivors may require a variety of services catering to their medical, emotional and psychological needs at different points: one qualitative review suggests that many victim-survivors characterise "the process of healing from sexual violence [...] as a long, challenging, tedious and non-linear process" (Draucker et al, 2009: 370). Streamlining the help seeking process, removing time limits on accessing support and reducing the number of times victim-survivors need to disclose to a new point of contact, could be considered a trauma- and evidence-informed approach to promoting recovery.

'The strategic join up is not there [...] It has always fallen on the voluntary sector to join our own services up. So, there I believe there've been really missed opportunities by commissioners to say, "Well, we commission these number of services, who delivers broadly sexual violence services? Why don't we get them in a room and do commissioning a bit differently [...] Well, let's have a look at the data actually. Let's see who's dealing with what number of referrals or cases and commission accordingly". That intelligence is not applied across our system and that is because we haven't brought all this information together into one place. So, you know, previously I think that's been a massive gap.'

(Interview, Practitioner, 2)

When asked about the range and kinds of services they felt would be most beneficial to local victim-survivors, and whether current provision reflected this picture, interviewees identified several key areas where they felt a more joined-up and evidence-informed approach was needed. This included reliably capturing, resourcing for, and responding to patterns of local need, including improving accessibility for marginalised and disabled service users, and recognising the majority of victim-survivors who choose not to, or do not feel able to, report to police. As one interviewee commented, there is currently no shared 'golden thread' of data about the level and patterns of need locally, because police data only reflects a minority of those affected by sexual violence. Another interviewee echoed this view, noting the need for enhanced data sharing in addition to police data.

A 'one-size-fits-all' approach is not conducive to equal and effective support for underrepresented individuals. Despite their increased risk of being targets of sexual violence, research that directly explores the needs of those from LGBTQ+ and/or ethnic minority backgrounds is still significantly underexplored (Clarke, Hyde & Caswell, 2023; Ward & Puleston, 2025). Men and those from ethnic minority backgrounds are less likely to seek support following the disclosure of sexual violence, likely due to stigma, cultural, language, religious and familial factors not currently accounted for by most

support provision (Chowdhury & Winder, 2022; Damery et al., 2024; Lowe, 2018; Olabanji, 2022). SARCs also possess limited mental health expertise required to effectively screen and refer individuals accordingly such that individual mental health needs are not consistently met (Hughes et al., 2023).

Interviewees working with children and young people also advocated for building a more holistic understanding of victim-survivors' needs, based on an ongoing, relational approach to engaging with service users, rather than working from a time-limited 'snapshot' view.

> *'A system that is completely victim-centred, that responds to client/survivor feedback and offers the relevant support/treatments without challenge or delay. A system that offers a variety of specialist therapeutic services, where professionals work in conjunction with one another as part of a multi-agency approach.'*
>
> **(Survey, Practitioner, 2)**

Responses from victim-survivors, professionals and commissioners who participated in the public call for evidence suggest that, while specific service providers and commissioners enjoy positive and trusting working relationships, the wider picture of local commissioning remains somewhat disjointed. Identified areas of inconsistency or confusion included the intersections between/nesting of VAWG, domestic abuse and sexual violence, and where the responsibility for commissioning services addressing each of these sits, as well as sexual violence's perceived role as a 'poor relation' relative to domestic abuse when it comes to funding and awareness. Some interviewees also highlighted the potential for duplication in service offers if commissioners do not consider how new services may complement, or overlap with, existing services.

This sentiment was echoed by one participant, who described efforts to shift towards providing longer-term funding for sexual violence and domestic abuse services where possible, in recognition of the expressed need for continuity and job security for specialist service providers. The need for the provision of specialist, local support for victim-survivors is **Recommendation 3** of this report.

> *'One of the things we've done is to give some of these organisations longer term funding [...] And I think that's really important because it helps with the continuity for those who are employed [...] You don't lose the expertise because [...] if you're not sure about your job security [...] You'll take all your knowledge and expertise with you. So, that's a lot better than it was.'*
>
> **(Interview, Commissioner, 1)**

Conclusions and Recommendations

The most recurrent themes identified whilst mapping service provision in Suffolk between 2022-2024 were in relation to:

1. Greater certainty of, and need for, long-term funding for existing services.
2. Funding as the key enabler to create more practitioner capacity to meet demand.
3. Terminology and language used must be clearly defined in policy and practice going forward.
4. The consideration of a 'one-door' entry service, which would facilitate more 'joined-up' working and signpost more effectively to victim-survivors at the point of triage.
5. The strength of the working relationships between victim-survivors, practitioners and commissioners.

We have listened to the voices of the key stakeholders who access, provide and commission sexual violence services in Suffolk. We have gained a significant picture of sexual violence provision in the Suffolk area, although there are more areas which should be explored.

In Suffolk, there is a need for more specialised services tailored to the unique needs of specific groups, such as LGBTQ+ individuals, males, survivors with disabilities and those from diverse cultural backgrounds. Notably, participants in the victim-survivors call for evidence were predominantly women, heterosexual, White British and non-disabled, suggesting that consultation of local victim-survivors from a more diverse range of communities, experiences and backgrounds may be beneficial in identifying and meeting neglected and/or intersecting areas of need. Existing services in Suffolk may not always be adequately equipped to provide culturally competent and inclusive support. Effective support for survivors often requires coordination and collaboration among various agencies, including the police, healthcare providers, social services, and legal professionals. However, there can be a lack of integration and seamless pathways between these different services, leading to gaps and inefficiencies.

Recommendation 7 of this report focuses on the need for further insight into sexual violence in areas where we have limited knowledge, including those who have experienced sexual violence by different demographics, such as ethnicity, gender and from other minoritised groups. To promote accessibility and relevance, future research should be co-produced with victim-survivors, including those from seldom heard groups, and commissioners should seek to establish an ongoing, relationship-based model of engagement with local victim-survivors, rather than sporadic, need-driven consultation exercises. As one interviewee noted, there is a clear appetite for such an approach among local people affected by sexual violence:

> *'There's some really interesting insights when talking directly with survivors. [One] was "Why do you only talk to us when you want to do a strategy?" That was brilliant. It's true that we should have an independently supported lived experience panel that we can go to regularly. A check and balance and an audit of what we do and if we're doing a campaign for example, "What do you think is the right way to do it? How would you do it?".'*
>
> **(Interview, Commissioner, 4)**

The increased demand for victim-survivor support in Suffolk cannot be met due to insecure funding. We have highlighted the enormous amount of work which is undertaken by a small number of dedicated practitioners. There is an appetite for a 'one-door' entry approach at the point of triage for victim-survivors. Such a model in Suffolk would coordinate support and provide signposting to those

who need it, whilst retaining direct access to existing services. Support for victim-survivors is the key message, which needs to be trauma-informed and needs-led, specialised (where applicable), with clear terminology, use of language and messaging. A time-limited, competitive funding climate and economic stressors at the national level creates uncertainty locally in Suffolk, rendering long-term planning challenging for providers.

Based on the findings from our investigations, our recommendations have been co-produced by the commissioners of this report and the research team. We have proposed a definition of sexual violence for immediate use:

> *Sexual violence means unwanted sexual behaviour that happens against a person's will. It may involve physical force or violence or, more commonly, other forms of coercion (pressure), including threats, manipulation or power over the affected person.*

Additional consultation with victim-survivors and professionals could support the accessibility and acceptability of the proposed definition and inform the development of an easy read definition to promote wider accessibility for children and young people, people with learning difficulties and people with learning disabilities. Victim voice and understanding the lived experience of victim-survivors is fundamental to all outcomes and must be central to all recommendations. They are as follows and are linked throughout the report:

1. The landscape of funding is precarious for all stakeholders. Coordinated action should be taken by commissioners and service providers to advocate for greater certainty of future funding, both locally and nationally.
2. The terminology and language used in policy, practice and communication with service users and the public should be co-produced and clearly defined, to ensure it can be understood by all.
3. The needs of victim-survivors far outweighs the level of support currently provided. Commissioners must commit to enhanced collaboration and multi-agency working, to ensure prioritisation of specialised local support, particularly for children and young people.
4. Demand should be managed through the coordination of a 'one-front door' entry, to enable a greater provision of services, whilst retaining direct access to existing services.
5. Prevention and early intervention are needed, including for children and young people and with potential perpetrators, to reduce the risks and harms associated with delayed disclosures.
6. Commissioners must commit to supporting a whole system, trauma-informed approach to sexual violence provision, with responsibility for setting service providers key performance indicators for trauma-informed communications and practice.
7. Service providers must take a more robust and consistent approach to the accurate collection and recording of data. The higher quality data that will be produced will provide greater insights into the specific needs of those who identify as male and those from minoritised groups, including by ethnicity and gender and create an evidence base of needs for future funding.
8. A commitment is required from commissioners, via funding and resourcing, to develop a local evidence base for best practice which can inform the prioritisation of local and national funding.

We present our findings and recommendations for your consideration, to inform Suffolk's future approaches to commissioning and delivery of sexual violence services.

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